COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1962

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

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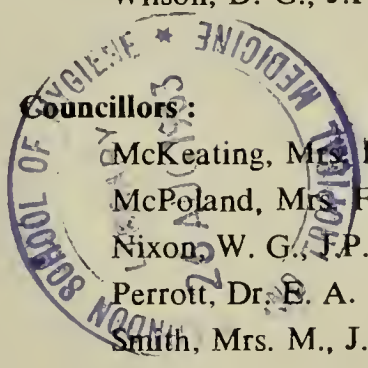
HEALTH COMMITTEE, 1962

Chairman : Alderman R. F. Dickinson, J.P.

Vice-Chairman : Alderman Mrs. E. G. Cain, O.B.E., J.P.

Aldermen :

Curwen, Mrs. J. N. St. G., J.P.
McCann, Rev. F. K.
Stephenson, W., J.P.
Wilson, D. G., J.P.



Councillors :

Askew, J.
Bainbridge, J. J.
Barton, Dr. E. B.
Bland, T. P., J.P.
Dickinson, D. L.
Dixon, W.
Gaffney, C.
Johnston, T. W.
Kilbride, J.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Nixon, W. G., J.P.
Perrott, Dr. E. A.
Smith, Mrs. M., J.P.
Thomas, H.
Vane, Mrs. M. F., J.P.
Wilson, Mrs. M. A., J.P.

Ex-Officio Members :

Chairman of County Council : Westoll, J., J.P.
Vice-Chairman of County Council : Edmonds, C., J.P.
Chairman of Finance Committee : Highton, L., J.P., D.L.

External Members :

Cartmel, Mrs. M. C.
Collins, R. G.
Faulds, Dr. J. S.
Ferguson, Dr. T. T., J.P.
Fletcher, Dr. A. F.
Grant, Dr. R. N. R.
Hasell, Mrs. G., O.B.E., J.P.
Hodgson, Mrs. H. L.
Long, R.
Ritson, C., J.P.
Rolland, Dr. C.
Whiteley, Miss D. I.
Wood, Mrs. C. H.
Young, A., M.B.E.

PREFACE

To the Chairman and Members of the Cumberland County Council.

Mr. Chairman, Ladies and Gentlemen,

Viewing in retrospect the work of the Health and Welfare Department in Cumberland during the year 1962, I feel that all those working in the department can have a justifiable sense of pride in the achievement of sound progress in many matters appertaining to the health and welfare of the Cumbrian.

The year has been marked by much thought on an administrative plane about the future of the department, the type of work that will be carried out by it, the type of worker of the future, and the buildings in which they will work.

While the overall pattern for the future is still in the main shaped by the generally accepted concept of a domiciliary team led by the General Practitioner, certain local health authority functions have been called into question, notably those of the Child Welfare Clinic, and certain responsibilities with regard to the aged and infirm, the chronic sick and the mentally disordered. In the last few years the field of work of health visitors, the field of social work generally, and recently general practice itself, have been officially surveyed.

In considering the background of future development, one must take account of the idea of the district general hospital, of increasing out-patient diagnosis and treatment, and the development of the psychiatric and geriatric services which have been amply demonstrated in Cumberland in the last few years. At the same time general practice has seen the growth of group practice and of research by general practitioners who have an increased participation in preventive services, assisted as they are by local authority nurses, midwives and health visitors. One thing is obvious — that the change in the pattern of domiciliary services must inevitably continue into the next ten years. It appears that if one accepts the principle that every hospital should only provide diagnostic and treatment services, then this principle will have a far reaching consequence for the local authority. The medical reasons for admission to hospital will have to be further scrutinised,

and indeed the question as to whether admission is necessary at all, will have to be carefully determined.

The local health authority in the future surely must plan increased availability of the domiciliary team linked both to the hospital and the general practitioner, offering greater scope for the joint use of staff and premises. That a start has already been made along this line of thought in Cumberland is clear from the advanced state of attachment of health visitors to general practitioner groups, and the use in certain areas of clinic premises for immunisation and ante-natal work associated with general practitioner/obstetricians and the domiciliary midwife. This way ahead is being further considered in this County at the planning stage of the Penrith Hospital. In the future it is hoped that the planning of health and welfare services will be on the basis of the total services required in the county whether they be primarily for the hospital, the general practitioner or the local health authority, with each providing a planned component of that total and making full use of voluntary services which may be available. The superimposition of the idea of the systematic use of voluntary services for community care and after-care is a development of cardinal importance.

This changing pattern of local health services in the next decade will be reflected in the functions of the individual members of the professional staffs of the local health authority, in particular the scope of the Health Visitor's work in relation to the increased number of trained social workers which will then be available. The changing role of the local authority medical officer in child health work must also be taken into account, as must the increasing work of the general practitioner in the preventive services for mothers and children in his practice. The veer in the method of deployment of local authority staff from a geographical distribution to a direct attachment to doctors' practices will have to be further examined and put into practice if suitable. This is particularly indicated in maternity and child health, mental disorder, chronic sickness and the care of the aged infirm.

One of the basic concepts at the centre of thought on future services which must be taken into account, is the increasing acceptance and use of the practice of concentrating effort on those known to be 'at risk' of disease and disability, as for example with certain

groups of infants or with the elderly. As a corollary to this we have screening tests for early detection of disease.

These thoughts refer to the future, but the present is gladdened by the authority having closed an old institution, long past its day, and seen the residents transferred to two modern homes with an increase in their interest in life and real enjoyment in their new circumstances. This move indeed proved to all, if proof had been needed, that apathy and boredom breed dependence, and behaviour is governed to a great extent by environment.

Area administration of this large county of a million acres and a quarter of a million inhabitants has been approved in principle. Already there has been some de-centralisation. Many of the day to day welfare duties have been delegated to district medical officers, who will thus, in their areas, become the central administrative points in the day to day work in this field.

This is the first year of integration of the health and welfare departments, and it has proved to be a great success, integrating all forms of social service both for the handicapped and the elderly.

Seven committees have been set up, on an area basis, to co-ordinate the work of voluntary bodies. Many anxious moments have been spent in the latter half of the year in considering the methods which could be used to implement the two important Ministry circulars on this subject, and ultimately local co-ordinating committees, under the chairmanship of the Medical Officer of Health have been set up with representatives of all voluntary bodies actively engaged in the particular area. It is expected that together with the responsible officials they will act in much the same way as the committees set up to prevent child neglect in the home. It will be of great interest to us all to see how this scheme develops.

The chiropody service has blossomed by 60 per cent. during the year, and this very necessary service is now being hampered more by shortage of chiropodists than by lack of funds.

No health department can be active unless it is engaged in research, and three surveys have been in progress in this department during the year. The first is associated with the community attitudes to child welfare clinic attendance. The second is associated with an investigation of cases of suicide in Cumberland dur-

ing the last decade. By the end of the year the third investigation, a survey of the social conditions of a random sample of 400 elderly residents in the county, aged 75 or more, had been approved by the Council and will be carried out in the summer of 1963.

The vital statistics of the county are included in this report, and I would underline a point which is often forgotten and which becomes very clear when one compares the statistics of 50 years ago with those of 1962. Middle age male deaths have not lessened during this period, and middle aged men are still dying in as great numbers as they did half a century ago, but from different causes. Bronchitis, heart disease and malignant disease are the three main causes of these deaths, and it seems clear that the parts played by excessive smoking of cigarettes, by over-eating, and by lack of exercise, are matters which must engage the attention of a service designed to prevent illness.

The heavy price to be paid for the training of staff has been faced by the authority, and the qualitative progression of staff training is continuing to keep pace with the quantitive demands. During the year a full complement of mental welfare officers on an area basis was established, and a community care service developed for all types of mental disorders along the lines of the Mental Health Act. The increasing emphasis on community support for those who have been mentally ill and treated as in or out-patients of hospitals, or in those cases where the practitioner asks for care and social support, has now proved to be a greater and increasing part of the mental welfare officers' work than it was in the past.

In the midst of a report dealing with the forward surge of social medicine in Cumberland, it will come as a surprise to note that in the middle of the year the first phase of a directly operated, radio-controlled ambulance service came into operation. I am pleased to say that the service is fulfilling all the high expectations that I had of it. It is completely controlled and a much better service can be given by a corps of ambulance men who are far more highly trained both theoretically, practically and by experience than ever could have been the case in a contractual service.

It will be noticed from the report that during the year child welfare clinics have been opened in 5 places, and closed in 1; that the first two male district nurses started in employment, and that a scheme was put into operation for Queen's Nurse training of

nurses working in the County who had not already been so trained. The future of the domiciliary midwifery service has received close study in the light of developments in the hospital services. Widely ranging discussions are still in progress with a view to establishing a clearer pattern for the future in this service.

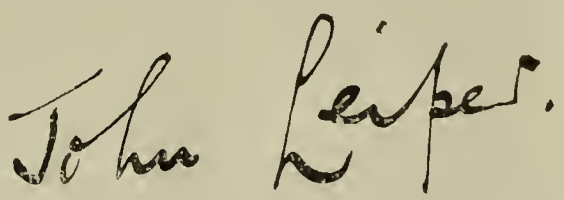
During the year there has been an increasing awareness of the complementary nature of much of the department's work with the hospital service, and on many matters progress has been made. In some respects the same holds true for the general practitioner service. The great realisation during the year, however, has been the need to use and co-ordinate the voluntary services to a much greater extent.

I feel, Mr. Chairman, that the year represents solid achievement on all fronts, and that it has been a year in which the advance is such that the Committee may be proud.

My thanks are due to the members of the Council, especially the Chairman of the Health Committee, to my fellow heads of departments of the Council, and last, but by no means least, to all members of the health department whose sheer hard work and concentration have been invaluable in a year of such progress.

I am, Ladies and Gentlemen,

Your Obedient Servant,



County Medical Officer

County Health Department,
11 Portland Square,
Carlisle.
June, 1963. Telephone No.: Carlisle 23456

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Assistant County Medical Officers, and District Medical Officers of Health—

J. L. Hunter, M.B., Ch.B., D.P.H., Senior Assistant County Medical Officer and Medical Officer of Health, Workington Borough.

J. N. Dobson, M.B., Ch.B., D.P.H., Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

J. R. Hassan, M.B., Ch.B., D.Obst.R.C.O.G., Medical Officer of Health, Alston Rural District (also general practitioner).

T. F. M. Jackson, L.R.C.P., L.R.C.S., L.R,F,P,S, D,P,H, Medical Officer of Health, Millom Rural District (resigned 2.11.62).

J. Patterson, M.B., B.Ch., B.A.O., D.P.H., Medical Officer of Health, Cockermouth Rural and Urban Districts and Keswick Urban District.

H. C. T. Smith, M.B., Ch. B., D.P.H., D.P.A., Medical Officer of Health, Wigton Rural District and Penrith Urban District.

K. J. Thomson, M.B., Ch.B., D.P.H., Medical Officer of Health, Border Rural District and Penrith Rural District.

Assistant County Medical Officers—

E. M. O. Campbell, M.B., Ch. B., D.P.H., D.T.M. and H.
A. B. C. Halliday, M.B., Ch.B. (resigned 30.9.62).
C. H. Mair, L.R.C.P., L.R.C.S.(Ed.), D.P.H.
E. M. Spencer, M.B., Ch.B.

DENTAL—

Chief Dental Officer—

R. B. Neal, M.B.E., L.D.S.

Dental Officers—

J. A. G. Baxter, L.D.S. (commenced 1.7.62).
I. R. C. Crabb, L.D.S.
D. H. Hayes, B.D.S.
M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
A. MacDonald, L.D.S.
I. H. Parsons, L.D.S. (commenced 4.6.62).
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.
A. M. Scott, L.D.S.
J. Watson B.D.S., L.D.S. (resigned 30.4.62).

WELFARE SERVICES—

Welfare Services Officer—

S. Hodgson, F.C.C.S.

Welfare Officer—

F. Lewthwaite.

Manager/Matron of Residential Accommodation—

Mrs. H. M. Abbott, Castle Mount, Egremont.
Mrs. F. Davies, Derwent Lodge, Papcastle.
G. C. Dryell, Station View House, Penrith.
Miss B. Edgar, Grange Bank, Wigton.
Mrs. A. Hill, Parkside, Maryport.
P. A. Howe, Highfield House, Wigton.
Mrs. K. L. Lewthwaite, S.R.N., S.C.M.
Richmond Park, Workington.
Miss E. M. Rogers, The Croft, Kirksanton.
Mrs. D. Smitham, S.R.N., Garlieston, Whitehaven
Miss V. Woodman, S.R.N., The Towers, Skinburness.

MENTAL HEALTH—

Consultant Psychiatrists (Part-time) seconded from Newcastle-upon-Tyne Regional Hospital Board—

J. R. Stuart, M.B., Ch.B., D.P.M.

T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Mental Health Officer—

N. Froggatt.

Senior Mental Welfare Officer—

E. L. Mayoh, A.A.P.S.W.

Mental Welfare Officers—

G. Cowham, R.M.N.

J. A. Denton, S.R.N., R.M.N.

M. H. Payne.

A. M. Bradley, S.R.N., R.M.N. (commenced 1.1.62).

Miss E. F. Hall.

J. C. Tanti.

Miss E. Welch.

Psychiatric Social Workers—

Miss M. Lamb (part-time), (resigned 26.1.62).

Training Centre Supervisors—

Miss G. L. Lister, Whitehaven.

Miss N. Macphearson, Wigton.

NURSING STAFF—

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., S.C.M., Q.N., H.V.Cert.

Assistant Superintendent Nursing Officers—

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert., P.H. Admin. Cert.

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert., R.F.N. (commenced 8.10.62).

NURSES QUALIFICATIONS CODE

1. S.R.N., R.G.N.
2. S.C.M.
3. Q.N.
4. H.V. Cert.
5. P.H. Admin. Cert.
6. R.F.N.
7. S.E.N.
8. R.S.C.N.
9. O.N.C.

Health Visitors—

*Miss A. Dixon, 1, 2, 4.
Penrith.

*Miss B. W. Knibbs, 1, 2, 3, 4.
Brampton.

*Mrs. M. McCredie, 1, 2, 4.
Penrith.

*Mrs. A. W. E. Maughan, 1, 2, 4.
Longtown.

*Miss E. Mercer, 1, 2, 4.
Wigton.

*Mrs. M. C. Roberts, 1, 2, 4.
Aspatria.

*Miss G. Davies, 1, 3, 4.
Workington.

*Mrs. B. L. Goodson, 1, 2, 4.
Workington.

*Mrs. M. Hewitson, 1, 2, 4.
Workington.

Miss M. Horn, 1, 2, 4.
Cockermouth.

Miss F. Kendall, 1, 2, 4.
Maryport.

Mrs. M. Lythgoe, 1, 2, 4.
Workington.

Miss M. McCann, 1, 2, 3, 4.
Maryport.

*Miss J. E. Surtees, 1, 2, 4.
Seaton.

Miss S. Twigg, 1, 2, 3, 4.
Maryport.

*Miss I .M. Alcock, 1, 2, 4.
Whitehaven.

*Mrs. S. Bowe, 1, 2, 4.
Whitehaven.

Miss E. Crosby, 1, 2, 4.
Egremont.
Miss M. E. Gibson, 1, 2, 4.
Egremont.
Miss A. M. Greggain, 1, 2, 3, 4.
Frizington.
Miss A. M. Little, 1, 2, 4.
Millom.
*Miss R. A. Lodge, 1, 2, 4.
Whitehaven.
*Mrs. A. Petch, 1, 2, 3, 4.
Whitehaven.
Miss R. Shepherd, 1, 2, 3, 4.
Cleator Moor.

* Seconded to General Practitioners.

District Nurse/Midwife/Health Visitors—

Miss M. A. Barclay, 1, 2, 3, 6.
Greystoke.
Mrs. E. C. Barnes, 2, 7.
Lanercost.
Miss A. Bowler, 1, 2, 3, 4.
Caldbeck.
Miss J. R. N. Byers, 1, 2, 3.
High Hesket.
Miss E. M. Chalkley, 1, 2, 3.
Langwathby.
Miss A. A. Cockton, 1, 2, 3, 6.
Burgh-by-Sands.
Miss L. R. Douglass, 2, 7.
Skelton.
Mrs. F. A. Gaskin, 1, 2, 3.
Irthington.
Miss M. Hastings, 1, 2, 3, 4.
Houghton.
Mrs. M. Hedworth, 1, 2, 3.
Abbeytown.
Miss E. Henderson, 1, 2, 3.
Langwathby.
Mrs. D. M. Lancaster, 1, 2, 3, 4.
Wigton.

Miss F. McGrath, 1, 2, 3, 4.
Dalston.
Mrs. M. J. Matthews, 1, 2, 3, 4.
Watermillock.
Mrs. E. E. Rome, 2, 7.
Kirkbride.
Miss N. D. Sanderson, 1, 2, 3, 4.
Bewcastle.
Miss E. M. Wallace, 1, 2, 3.
Wetheral.
Miss M. Weightman, 1, 2, 3.
Scotby.
Miss B. M. Wesson, 1, 2, 3.
Hayton.
Miss M. Worrell, 1, 2, 3, 4.
Alston.
Miss I. Arnott, 1, 2, 3.
Threlkeld.
Mrs. C. Butcher, 1, 2, 3.
Bassenthwaite.
Miss M. Casey, 1, 2, 3, 4.
Keswick.
Mrs. A. Donald, 1, 2, 3, 4.
Oughterside.
Miss S. J. Graham, 2, 7.
Brigham.
Mrs. M. Hall, 2, 7.
Relief.
Miss J. M. Hillhouse, 1, 2.
Keswick.
Miss A. R. Hobbiss, 1, 2, 3, 4.
Lorton.
Mrs. N. Hodgson, 2, 7.
Broughton.
Miss S. M. J. Iliffe, 1, 2, 3.
Borrowdale.
Miss C. F. M. McKnight, 1, 2, 3, 4.
Dearham.
Miss R. W. Ventress, 1, 2, 3, 4.
Bothel.

Mrs. I. E. Bowe, 1, 2, 3, 4.
Bootle.
Mrs. J. A. Graham, 1, 2, 3, 4.
Distington.
Miss J. A. Hardie, 1, 2, 3, 4.
Parton.
Miss D. D. James, 1, 2, 3, 4.
Seascale.
Mrs. M. Marshall, 1, 2, 3.
Muncaster.

District Nurse/Midwives—

Miss A. E. E. Burfield, 1, 2, 3.
Wigton.
Miss E. M. Dixon, 1, 2, 3.
Longtown.
Miss J. Gibbs, 1, 2, 3.
Longtown.
Miss E. C. Guthrie, 1, 2, 3.
Silloth.
Miss A. M. Holliday, 1, 2, 3.
Aspatria.
Mrs. F. M. Hurst, 1, 2, 3.
Brampton.
Mrs. M. Jackson, 2, 7.
Penrith.
Mrs. I. Penn, 1, 2, 3.
Penrith.
Miss A. Stidson, 1, 2, 3.
Alston.
Mrs. M. E. Wilde, 1, 2, 3.
Relief.
Miss K. Winter, 1, 2, 3.
Penrith.
Miss M. G. Beattie, 1, 2, 3.
Great Clifton.
Miss A. Chadwick, 1, 2, 3.
Maryport.
Mrs. C. M. Gate, 1, 2, 3.
Maryport.
Miss A. Jackson, 1, 2.
Seaton.

Miss A. I. Kirk, 1, 2, 3.
Cockermouth.
Mrs. H. M. McCallam, 2, 7.
Relief.
Miss M. Musgrave, 1, 2, 3.
Cockermouth.
Miss O. Pickering, 1, 2, 3.
Maryport.
Miss A. Armstrong, 1, 2, 3.
Egremont.
Mrs. I. Booth, 1, 2.
Relief.
Mrs. G. Connolly, 1, 2.
Relief.
Miss C. O. Grosvenor, 1, 2, 3, 4.
Millom.
Miss C. E. Hall, 1, 2, 3.
Egremont.
Miss F. Lonsdale, 1, 2.
Seascale.
Miss M. Proctor, 1, 2, 3.
Frizington.
Miss H. Spencer, 1, 2, 3.
Frizington.
Miss D. Waterhouse, 1, 2, 3.
Millom.
Mrs. J. White, 2, 7.
Egremont.

Midwives—

Workington—

Mrs. S. E. Fields, 1, 2.
Mrs. M. M. Hind, 2, 7.
Mrs. M. K. Tunstall, 1, 2.

Whitehaven and Cleator Moor

Mrs. M. Ainsworth, 1, 2.
Miss E. M. Miller, 1, 2, 3.
Miss A. Singleton, 1, 2.
Miss M. Stephenson, 1, 2, 3.

District Nurses—

Mrs. J. A. Branthwaite, 1.
Relief.
Mrs. R. M. Gultnieks, 7.
Relief.
Mrs. E. J. Relph, 1.
Penrith.
Mrs. J. E. Barnes, 1, 2, 3.
Relief.
Mrs. E. Fagan, 1.
Workington.
Mr. T. D. M. Holmes, 1, 3.
Workington.
Mrs. M. I. Lowis, 1.
Workington.
Mrs. S. E. Scott, 2, 7.
Relief.
Miss M. Young, 1, 2, 3, 8.
Workington.
Mrs. A. Maguire, 2.
Workington.
Mr. N. Blackburn, 1, 3.
Whitehaven.
Mrs. E. Brannon, 1.
Whitehaven.
Miss O. G. Coates, 1.
Whitehaven.
Mrs. F. Corkhill, 1.
Egremont.
Mrs. H. Egan, 1, 6.
Relief.
Mrs. D. Jolly, 1, 2.
Relief.
Mrs. L. Messenger, 1, 2, 3.
Workington.
Mrs. I. Routledge, 1, 2.
Whitehaven.
Mrs. M. T. Toole, 1.
Cleator Moor.
Miss J. Woodend, 1, 3.
Whitehaven.

School/Clinic Nurses—

Mrs. E. Knudston, 1.
Workington.
Mrs. M. E. Sansom, 1, 2.
Relief.
Miss D. Wise, 1, 2, 3, 6.
Workington.
Mrs. E. M. Maguire, 1, 2, 9.
Whitehaven.
Mrs. B. F. Wilson, 1.
Whitehaven.

Audiometricians—

Mrs. M. G. Hicks.
Miss R. M. Thompson (commenced 19.10.62).

Chiropodist—

G. H. Thomas, M.Ch.S.

Orthopaedic Physiotherapists—

Miss J. M. Morris, M.C.S.P., M.E.
Miss J. A. Fraser, M.C.S.P., O.N.C.

Orthoptist—

Miss J. Modlin, D.B.O. (resigned 1.4.62).

Speech Therapists—

Miss C. M. Allan, L.C.S.T.
Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

ADMINISTRATION

For the administration of the county health service, the local health authority — the County Council — appointed a Health and Housing Committee. It, in turn, has four standing sub-committees — General Purposes, Nursing, Mental Health and Welfare. In addition there is a Joint Health and Education Sub-Committee composed of representatives of both the health and education committees to deal with matters pertaining to the health of the school children; and lastly, a Joint Committee of representatives of the County and Carlisle Health Committees was established during 1962 to administer the Workshops for the Blind.

In addition to its 26 representatives of the County Council, the Health and Housing Committee also has 15 "external members" who represent the medical, dental, pharmaceutical and nursing professions, and the hospital management committees, who are co-opted for their special interest in some branch of the service. In this way a wide variety of interests and lines of thought, all with the well-being of the health and welfare services in general as their prime objective, are brought to bear on the framing of policy.

The policy having been decided, the problems are handled administratively by myself and my staff and, where appropriate, by other departments. So far as the health department is concerned the administration is still mostly through the central office in Carlisle, with certain day to day matters mostly affecting the school health service in West and South Cumberland being conducted by the Senior Assistant Medical Officer in the area office in Whitehaven. However, for some time it has been getting more obvious that with the expansion of the service it is becoming difficult to deal adequately with day to day matters from the central office. The problem was increased with the integration of the welfare service and towards the end of the year the Health and Housing Committee considered how the position could best be met. As a result it was decided to accept in principle some form of area administration, on the understanding that details would be considered later.

The proposal is that the county should be divided into three areas, each of about 75,000 population, and that area offices should be established in Carlisle, Workington and Whitehaven, for the Northern, Western and Southern Areas respectively. The

Northern Area would comprise the rural districts of Alston, Border, Penrith and Wigton, and the urban district of Penrith; the Western Area would take in the Municipal Borough of Workington, the rural district of Cockermouth and the urban districts of Cockermouth, Keswick and Maryport; and the Southern Area would cover the Municipal Borough of Whitehaven and the rural districts of Ennerdale and Millom.

Already there has been some decentralisation of duties within the existing framework, matters relating to the home help service in the West and the South of the county being handled in the Whitehaven office and the Assistant County Medical Officers who are also District Medical Officers of Health have taken over certain welfare functions.

At the end of the year administrative and clerical staff numbered 45, of whom 11 were in the area office at Whitehaven. The establishment was filled. In addition, the Assistant Medical Officers who are also Medical Officers of Health have the assistance of clerks on the staffs of the district councils for the county work. Part of their salaries are paid by the County Council and in aggregate they amount to the equivalent of two full-time clerks.

The clerical staff at headquarters are organised into six main sections; ambulance, mental health, nursing services, school health, welfare and general purposes, each with an administrative assistant in charge. There is also an administrative assistant in charge of the clerical work at Whitehaven and there is some clerical assistance in the dental section.

It is of the greatest value in administering the County Health Service that I or my deputy can attend meetings of a number of committees outside the County Council, either as representatives of the authority, as co-opted members, or as observers. The main committees coming within this category are the Special Area Committee, the West Cumberland Hospital Management Committee, Garlands Hospital Medical Advisory Committee and the Local Medical Committee, and I find it most useful to be able to tell these bodies what the view of the authority is likely to be, or what my personal views are, before they take any policy decisions that may later affect the County Health Service.

In the case of the Local Medical Committee, it gives me an opportunity of explaining new county policies or services to the general practitioners and seeking their co-operation in carrying them out. To further this co-operation, which is so vital to the smooth running and efficiency of the service, an information bulletin is sent to all doctors at about four monthly intervals to help keep them in touch with the activities of the department.

There are also Local Maternity Liaison Committees in East and West Cumberland to which representatives of the three arms of the health service are appointed to discuss maternity problems.

Towards the end of the year it was decided to form a Health and Medical Services Liaison Group which would have representatives from the County Health Service, the Hospital Board, the County Executive Council, the Local Medical Committee for the County Executive Council, The Local Medical Committee for the County, Carlisle Health Committee, Carlisle Executive Council and Carlisle Local Medical Committee. This group will meet from time to time to consider major issues, such as future development or planning, which might be envisaged by one branch of the service and have some effect on the other branches. It is felt that such a group will meet a long felt need and ensure much fuller and closer co-operation in the early stages of planning.

For some years there has been in existence an Ambulance Liaison Committee, which had representatives of all the ambulance services running to the Carlisle hospitals. It had not met for some time, but it was felt that the reorganisation of the ambulance service in Cumberland might be an opportune time to reinstate it. A meeting was therefore held under the Chairmanship of the Principle Regional Officer of the Ministry of Health and regular meetings are to be held in the future.

The two monthly meetings of Assistant County Medical Officers have been continued and in addition there are now regular meetings of mental welfare officers, speech therapists, managers and matrons of Part 111 accommodation and home teachers of the blind. These conferences serve a most useful purpose.

Another way in which the administration of the service is helped greatly by "outside" connections is the joint appointment of Assistant Medical Officers. Most of them work for the County on about a half-time basis and are for the remainder of their time

Medical Officers of Health to District Councils. There are undoubted advantages in such an arrangement and the gap between the two duties that has always existed in the past is being closed by the delegation of welfare functions which I mentioned earlier.

During the course of the year an internal working party was established to consider the closure of the ex-Public Assistance Institution at Meadow View House, Whitehaven, the opening of two modern type homes to replace it and the various side effects of these changes. Working parties such as this have been found extremely useful in dealing with the major problms and I am indebted to my colleagues from other departments and to those from outside bodies who give of their time to advise me. At the end of the year a working party was being set up in conjunction with the Children's Officer to consider the problem of homeless families in this County.

A survey to try to ascertain why mothers do or do not attend child welfare clinics in the County was begun during the summer and continued during the remainder of the year. Most of the field work was undertaken by members of the W.V.S., and I am most grateful to them for their very valuable assistance. At the time of writing the survey has not been completed, but full details will be given in my next report.

The authority continued to be more fortunate than many others with staffing during the year. Two medical officers left, but were replaced with the minimum of delay and the only seriously affected section of the service was once again orthoptics, where we were without anyone in post for almost threequarters of the year. Although the establishment of orthoptists is two, we have been pleased to be able to get one for the past few years. Unfortunately, there does not seem to be any prospect of this situation improving unless Cumberland girls undertake the necessary training and return to the County for employment.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.

Rateable Value (April 1st, 1962)—£2,328,653.

Estimated product of 1d. rate (1962-63)—£9,365.

Population (Census, 1951)—217,540.

Population (Census, 1961)—223,050.

Population (1962 Mid-year estimate)—223,330.

Live Births—Number	4,085
Rate per 1,000 population	18.3
Illegitimate live births per cent. of total births	4.6
Still Births—Number	78
Rate per 1,000 total live and still births	18.7
Total live and still births	4,163
Infant death (deaths under 1 year)	108
Infant mortality rates—	
Total infant deaths per 1,000 total live births	26.4
Legitimate infant deaths per 1,000 total legitimate births	25.2
Illegitimate infant deaths per 1,000 total illegitimate births	52.9
Neo-natal mortality rate (deaths under 4 weeks per 1,000 total live births)	20.3
Early neo-natal mortality rate (deaths under 1 week per 1,000 total live births)	17.4
Perinatal mortality rate (Still births and deaths under 1 week combined per 1,000 total live and still births)	35.8
Maternal mortality (including abortion)	1
Rate per 1,000 total live and still births	0.24

A more detailed analysis of the above figures is given overleaf:

	Male.	Female.	Total.	Urban Districts.	Rural Districts.	Admin. County.	Eng'd and Wales. (prov.)
LIVE BIRTHS—							
Legitimate ...	2011	1885	3896				
Illegitimate ...	87	102	189				
	2098	1987	4085				
Birth rate per 1,000 population ...				18.3	18.3	18.3	18.0
STILL BIRTHS—							
Legitimate ...	32	37	69				
Illegitimate ...	2	7	9				
	34	44	78				
Still birth-rate per 1,000 total births ...				17.7	19.5	18.7	18.1
DEATHS—							
All causes ...	1433	1290	2723				
Death rate per 1,000 population ...				12.3	12.1	12.2	11.9
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	51	47	98				
Illegitimate ...	5	5	10				
	56	52	108				
Total infant deaths per 1,000 total live births				20.4	30.6	26.4	21.4

MORTALITY TRENDS IN CUMBERLAND

Year		Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1922	...	485	272	89	119	355	649	609	639	3218
		15.1%	8.5%	2.8%	3.7%	11%	20.1%	18.9%	19.9%	Rate 14.7
1932	...	257	89	59	120	252	623	649	743	2792
										Rate 13.6
1952	...	119	20	20	30	139	575	732	968	2603
										Rate 12.1
1953	...	97	15	18	32	135	560	717	997	2571
										Rate 11.9
1954	...	98	21	16	24	91	543	743	1031	2567
										Rate 11.9
1955	...	101	7	15	22	79	607	737	1075	2648
										Rate 12.2
1956	...	112	12	18	24	112	571	719	1085	2653
										Rate 12.2
1957	...	103	21	19	33	120	553	734	1057	2640
										Rate 12.1
1958	...	108	18	9	24	113	607	677	1087	2643
										Rate 12.1
1959	...	82	8	16	27	81	575	712	1110	2611
										Rate 11.9
1960	...	91	13	19	21	105	554	677	1149	2629
										Rate 12.0
1961	...	88	7	19	19	86	570	747	1189	2725
										Rate 12.3
1962	...	108	15	13	15	114	574	759	1125	2723
		4%	0.5%	0.5%	0.5%	4.2%	21.1%	27.9%	~~27.9~~ 4.3%	Rate 12.2

District	BIRTHS				
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor
URBAN DISTRICTS—					
Cockermouth ...	111	4	115	19.5	0.99
Keswick ...	39	3	42	9.2	1.00
Maryport ...	195	8	203	16.5	0.95
Penrith ...	177	7	184	17.1	1.01
Whitehaven ...	574	27	601	21.8	0.96
Workington ...	489	32	521	17.5	0.97
Aggregate ...	1585	81	1666	18.3	0.97
RURAL DISTRICTS—					
Alston ...	33	4	37	16.9	1.09
Border ...	480	24	504	16.7	1.15
Cockermouth ...	342	7	349	9.9	0.99
Ennerdale ...	654	34	688	21.9	1.01
Millom ...	258	11	269	17.8	1.02
Penrith ...	182	8	190	16.7	1.03
Wigton ...	362	20	382	17.6	1.02
Aggregate ...	2311	108	2419	18.3	1.04
Administrative County ...	3896	189	4085	18.3	1.01

ND POPULATION IN THE YEAR 1962

DEATHS			INFANT MORTALITY				
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Legitimate	Illegitimate	Total	Deaths of Infants under 1 year per 1,000 live births	Estimated mid-year population
74	12.5	1.05	—	—	—	—	5900
72	15.7	0.86	—	—	—	—	4590
144	11.7	1.16	9	—	9	44.3	12320
151	14.0	0.91	4	—	4	21.7	10790
310	11.2	1.12	14	1	15	25.0	27610
365	12.3	1.18	5	1	6	11.5	29710
1116	12.3	1.10	32	2	34	20.4	90920
33	15.1	0.94	—	1	1	27.0	2180
375	12.4	0.96	13	2	15	29.8	30190
250	12.2	1.07	4	—	4	11.5	20460
354	11.3	1.19	21	2	23	33.2	31450
154	10.2	1.13	6	3	9	33.5	15070
139	12.2	1.00	5	—	5	26.3	11390
302	13.9	1.02	17	—	17	44.5	21670
1607	12.1	1.06	66	8	74	30.6	132410
2723	12.2	1.08	98	10	108	26.4	223330

	Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.
	All Causes	2723	74	72	144
1.	Tuberculosis, Respiratory	12	—	1	1
2.	Syphilitic disease	4	—	—	—
3.	Meningococcal infections	1	—	—	—
4.	Acute Poliomyelitis	1	—	—	—
5.	Other infective and Parasitic diseases ...	1	—	—	—
6.	Malignant neoplasm, stomach ...	91	3	3	10
7.	Malignant neoplasm, lung bronchus ...	66	1	2	—
8.	Malignant neoplasm, breast	46	1	2	2
9.	Malignant neoplasm, uterus	19	—	—	1
10.	Other malignant and lymphatic neoplasms	212	4	10	13
11.	Leukaemia, Aleukaemia	12	—	1	—
12.	Diabetes	27	—	1	—
13.	Vascular Lesions of Nervous System ...	449	13	11	27
14.	Coronary Disease, Angina	550	16	9	35
15.	Hypertension with Heart Disease ...	53	1	4	2
16.	Other Heart Disease	312	7	12	11
17.	Other Circulatory Disease	144	4	3	4
18.	Influenza	12	3	—	1
19.	Pneumonia	85	3	—	3
20.	Bronchitis	96	3	3	11
21.	Other Disease of the Respiratory System .	27	—	1	2
22.	Ulcer of Stomach and Duodenum ...	32	3	2	1
23.	Gastritis, Enteritis and Diarrhoea ...	5	1	—	1
24.	Nephritis and Nephrosis	23	—	—	—
25.	Hyperplasia of Prostrate	11	1	—	—
26.	Pregnancy, Childbirth and Abortion ...	1	—	—	—
27.	Congenital Malformations	35	—	—	1
28.	Other defined and Ill defined diseases ...	279	4	2	10
29.	Motor Vehicle accidents	26	—	1	1
30.	All other accidents	68	2	1	4
31.	Suicide	23	4	3	3

DMINISTRATIVE AREAS (1962)

Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D.'s
310	315	1116	33	375	250	354	154	139	302	1607
1	2	5	1	—	—	3	1	—	2	7
—	—	—	—	—	1	—	1	—	2	4
—	—	—	—	—	—	—	—	1	—	1
—	—	—	—	—	—	1	—	—	—	1
—	—	—	—	1	—	—	—	—	—	1
12	11	45	1	10	14	10	1	4	6	46
3	11	22	3	11	4	11	4	3	8	44
7	6	22	—	4	2	10	4	2	2	24
2	3	7	—	4	2	2	2	—	2	12
14	31	83	4	35	19	20	9	11	31	129
1	2	5	—	1	—	2	1	1	2	7
3	2	6	—	6	7	4	1	2	1	21
49	68	194	10	54	44	55	30	11	51	255
45	71	212	3	76	40	79	43	40	57	338
13	4	25	—	11	2	7	1	1	6	28
22	38	117	2	50	35	20	12	21	55	195
18	14	51	1	24	18	25	4	8	13	93
—	1	5	—	1	1	4	—	1	—	7
14	11	33	1	16	12	13	4	2	4	52
10	10	44	2	11	12	13	2	4	8	52
3	1	7	—	3	1	6	—	2	8	20
3	7	17	1	3	3	5	1	2	—	15
—	—	2	—	—	—	—	—	1	2	3
2	1	5	—	4	—	5	6	1	2	18
1	3	5	—	1	2	2	1	—	—	6
—	—	—	—	—	—	—	—	1	—	1
5	1	8	—	6	5	7	3	2	4	27
66	46	137	3	25	21	39	18	9	27	142
4	6	13	—	6	—	1	—	4	2	13
12	12	32	1	11	5	9	4	3	3	36
—	3	14	—	1	—	1	1	2	4	9

BIRTH AND DEATH STATISTICS

Year	Estimated Mid-Year Population	Births		Deaths		Excess of Births over Deaths
		No.	Rate	No.	Rate	
1922 ...	218499	4863	22.3	3218	14.7	1645
1938 ...	194900	3092	15.9	2638	13.0	454
1947 ...	202460	4446	22.0	2788	13.8	1658
1951 ...	214700	3681	17.1	2827	13.2	854
1952 ...	215050	3714	17.3	2603	12.1	1111
1953 ...	216100	3608	16.7	2571	11.9	1037
1954 ...	216600	3533	16.4	2567	11.9	966
1955 ...	216700	3556	16.4	2653	12.2	903
1956 ...	217450	3679	16.9	2653	12.2	1026
1957 ...	217600	3901	17.9	2640	12.1	1261
1958 ...	217700	3834	17.6	2643	12.1	1191
1959 ...	218900	3888	17.8	2611	11.9	1277
1960 ...	219160	3940	18.0	2629	12.0	1311
1961 ...	221460	3900	17.6	2725	12.3	1175
1962 ...	223330	4085	18.3	2723	12.2	1362

SECTION 23

MIDWIFERY SERVICE

During the year 140 midwives notified their intention to practise. These include 8 whole-time midwives, 74 district nurse midwives working in urban and rural areas and 58 midwives working in the maternity department of hospitals in the administrative county.

The number of domiciliary confinements undertaken during the year was 1107, the doctor being present at 390 of these confinements. The total number of home visits paid by midwives in connection with the nursing care of the mother and baby after confinement was 91016, and in addition, 2759 visits were paid to 496 mothers who were discharged from hospital before the tenth day.

Ante-natal and post-natal examinations as distinct from nursing visits account for a large part of the midwife's time and 11588 visits were paid to expectant mothers in their own homes. In addition to this attendances made by expectant mothers to midwives' clinics were 5675 and a doctor was present at 3029 of these examinations.

Mothercraft and relaxation classes are becoming more popular. Hospital booked patients who are unable to attend the hospital classes are attending the classes held at the various clinics, e.g. Aspatria, Keswick, Maryport, Wigton. In Whitehaven there is excellent co-operation where the hospital and domiciliary midwives combine to hold classes in both hospital and clinic, there being good provision for relaxation in the rehabilitation centre at the hospital and a suitable room for film shows at the clinic. During the year 316 classes were held and 1244 attendances made.

Arrangements with pupil midwives from Workington Infirmary to take the three months district experience in the Whitehaven area has continued to function most satisfactorily during the year. Nine pupils completed the course at Whitehaven and Cleator Moor and all were successful in passing the Part II Examinations of the Central Midwives Board.

Midwives sent for medical help, according to the Central Midwives Board rules, on 164 occasions which are listed below :—

Ante-natal Period—

Antepartum haemorrhage	7
Hypertension, albuminuria, etc.	12
Threatened or complete abortion	1
Early rupture of membranes	3
Miscellaneous	1
Hydramnios	2
Marked anaemia	3
	29

During Labour—

Premature labour	1
Delayed labour during 1st or 2nd stage	18
Retained placenta and P.P.H.	20
Breech presenting	2
Antepartum haemorrhage	1
Ruptured perineum	41
Foetal distress	16
White asphyxia — baby	3
Blue asphyxia — baby	1
Malformation	3
Malpresentation	9
	115

During Puerperium—

Mother—	
Pyrexia	7
Baby—	
Discharging eyes—spots—vomiting	11
Cold injury	1
Jaundice	1
	20

The following table shows details of 153 cases which were booked for home confinement, but which later required admission to hospital. The extent of this problem as it is here revealed, certainly suggests strongly that at least in some cases a more judicious selection of hospital confinement in the first place might be possible.

Ante-natal Period—

Toxaemia of pregnancy	21
Premature labour	8
A.P.H.	15
Post maturity	8
R.H. negative	8
Any other reason	23

Complications of labour—

Delayed labour	27
Retained placenta	8

P.P.H.	3
Foetal distress	4
Any other reason	15
Post-natal—	
Condition of mother	2
Condition of baby	11

The trend towards hospital confinement has continued throughout the year and the following table shows the present position :—

Year	Domiciliary Births	Institutional Births	Total	% Institutional Confinements
1955 ...	1488	2167	3655	59
1956 ...	1584	2257	3841	59
1957 ...	1473	2556	4029	63
1958 ...	1413	2473	3886	64
1959 ...	1323	2674	3997	67
1960 ...	1225	2821	4046	70
1961 ...	1128	2809	3937	71
1962 ...	1148	2988	4136	72

It will be seen that there is an increase of 1% on hospital confinements during the year making a rate of 72%. This is already above the provision recommended by the report on the Maternity Services Committee (Cranbrooke Report 1958), and it seems that with the provision of more hospital beds in the area the percentage is likely to rise. The effect on the domiciliary service is apparent, and one of the major problems is finding a sufficient number of cases for the domiciliary midwife to keep in practise, particularly in rural areas where already 16 of the midwives have had less than 5 cases during the year. In Workington there are already too few cases for the midwives and one has relieved on the general nursing side for most of the year. Some re-organisation of the domiciliary midwifery service needs to be considered in the near future if we are to keep midwives in constant practise. Indeed if this trend continues there will be insufficient domiciliary confinements for pupil midwives to get the present required number of deliveries during the Part II Training; the present minimum number is 10 domiciliary confinements per pupil midwife. Unless the training regulations are amended it is possible in the not too distant future that the Part II Training Scheme will cease to operate in the County Area. This in turn will have an effect on the domiciliary training midwife who will need to seek other fields of work. This would be a retrograde step as a training scheme

adds stimulus to the midwifery service in the county and assists with the recruitment of staff in the area.

There is little evidence of patients being discharged too early from hospital, i.e. the 4th and 5th day. If this is necessary it is at the request of the patient and by arrangement with the hospital, family doctor and domiciliary midwife. The patient normally remains in hospital 8 — 10 days except in emergency when there is an unusual number of births in a short space of time.

High Risk Group

Of the 1107 cases confined at home 135 came in to the high risk group. These are the mothers whose age and previous confinements constitute a risk and who should be delivered in hospital. The following table shows the position during the last three years :—

Domiciliary Confinements

Age Group	Year	Number of Pregnancy 4	5	6	7	8	9	10 +	Total
	1960	—	—	—	—	—	—	—	—
	1961	—	2	3	—	—	—	—	5
20 —	1962	—	3	—	1	—	—	—	4
	1960	—	9	9	1	4	—	—	23
	1961	—	12	—	—	2	—	—	14
25 —	1962	—	9	4	—	—	—	—	13
	1960	—	21	15	6	3	3	2	50
	1961	—	23	7	3	1	1	—	35
30 —	1962	—	18	11	5	3	1	2	40
	1960	21	17	15	4	3	2	5	67
	1961	31	12	6	2	2	2	2	57
35 —	1962	21	15	9	3	4	1	—	53
	1960	6	5	—	5	1	1	—	18
	1961	6	4	3	1	3	1	1	19
40 —	1962	9	9	3	3	1	—	—	25
	1960	—	—	—	2	—	—	1	3
	1961	—	1	1	1	—	—	—	3
45 +	1962	—	—	—	—	—	—	—	—
TOTAL	1960	27	52	39	18	11	6	8	161
	1961	37	54	20	7	8	4	3	133
	1962	30	54	27	12	8	2	2	135

A number of these cases have been delivered in the rural areas where the midwives have the least number of cases. A better selection for both hospital and domiciliary confinement should be undertaken. The general practitioner and the midwife do endeavour to persuade the expectant mother to have her confinement in hospital wherever necessary but the "high-risk" mother who wishes to remain with her family and feels unable for various reasons to leave them even for the short period of 8 to 10 days while she is in hospital remains an obstinate problem. I believe that a sustained and concentrated effort is necessary to ensure the hospital confinement of those cases known to be especially "at risk," in terms of either baby's or mother's life or both.

This whole matter is intimately related to the subject of the perinatal mortality rate, which is dealt with in the next section of this report.

Local Maternity Liaison Committees

The Local Maternity Liaison Committees have continued to function during the year and have met three times in West Cumberland and three in East Cumberland. The subjects for discussion have included perinatal mortality rate, the prevention of prematurity and the At Risk register; general practitioner obstetric beds, the use of the standard co-operation card, future developments of the maternity services, health education for all expectant mothers, ratio of hospital and domiciliary confinements, salaries and training allowances for nurses and midwives H.M. (61)16.

That these Committees should have been formed, and regular meetings occurred, is in itself an important step forward. They are of purely professional membership, and the appropriate extracts from the minutes are transmitted to the Local Medical Committee and the Hospital Management Committees. This constitution allows of a very free exchange of views between the doctors and nurses present, and leads both to a clarification of points at issue, and to a measure of agreement on action. The subject which I regard as undoubtedly the one of major significance, and one which I have felt bound to keep constantly before the Committees, is the matter of selection of cases for hospital and home confinement. I am glad to say that the Committees have accepted in principle the advisability of all high risk cases being confined in hospital, but I am afraid that the figures shown in the last Table make it very clear that practice falls far short of the apparently agreed precept here. I have already commented on the serious situation

which has arisen in domiciliary midwives delivering only a small number of cases each year, an alarmingly high proportion of which are high risk cases. Meantime many normal cases are being needlessly delivered in hospital. Most useful as Local Maternity Liaison Committees are, at the limit of their effectiveness it is sometimes necessary to make more official contact with the other branches of the Maternity Services, as at present in connection with the subject mentioned above.

Analgesia for Home Confinements

During the year the gas and air analgesia was used by domiciliary midwives in 579 cases and trilene in 284 cases. Gas and air apparatus is available to all midwives and there are 16 trilene apparatus. Midwives also have an oxygen infant resuscitator which is found to be most valuable in resuscitating infants born in asphyxiated conditions.

The Flying Squad was called out 11 times from the Carlisle City Maternity Hospital or Workington Infirmary.

Use of Inhalational Analgesics by Domiciliary Midwives

Year	Deliveries Attended	Cases in which inhalational analgesics were administered					
		Doctor present at delivery		Doctor not present at delivery			
		Gas & Air	Trilene	Gas & Air	Trilene	Total	%
1957 ...	1396	222	—	800	—	1022	73.2
1958 ...	1367	245	—	726	11	982	71.8
1959 ...	1265	187	7	658	118	970	76.7
1960 ...	1151	224	16	587	217	1044	90.7
1961 ...	1043	189	66	380	206	841	80.6
1962 ...	1107	219	84	358	200	861	77.8

Post Graduate Courses

As required by the rules of the Central Midwives Board, 12 midwives attended refresher courses during the year at Bangor, Birmingham, Hull, Leeds, and Newcastle-upon-Tyne.

One of the Assistant Superintendent Nursing Officers attended a post graduate course for Supervisor of Midwives in London.

SECTION 22

CARE OF MOTHERS AND YOUNG CHILDREN

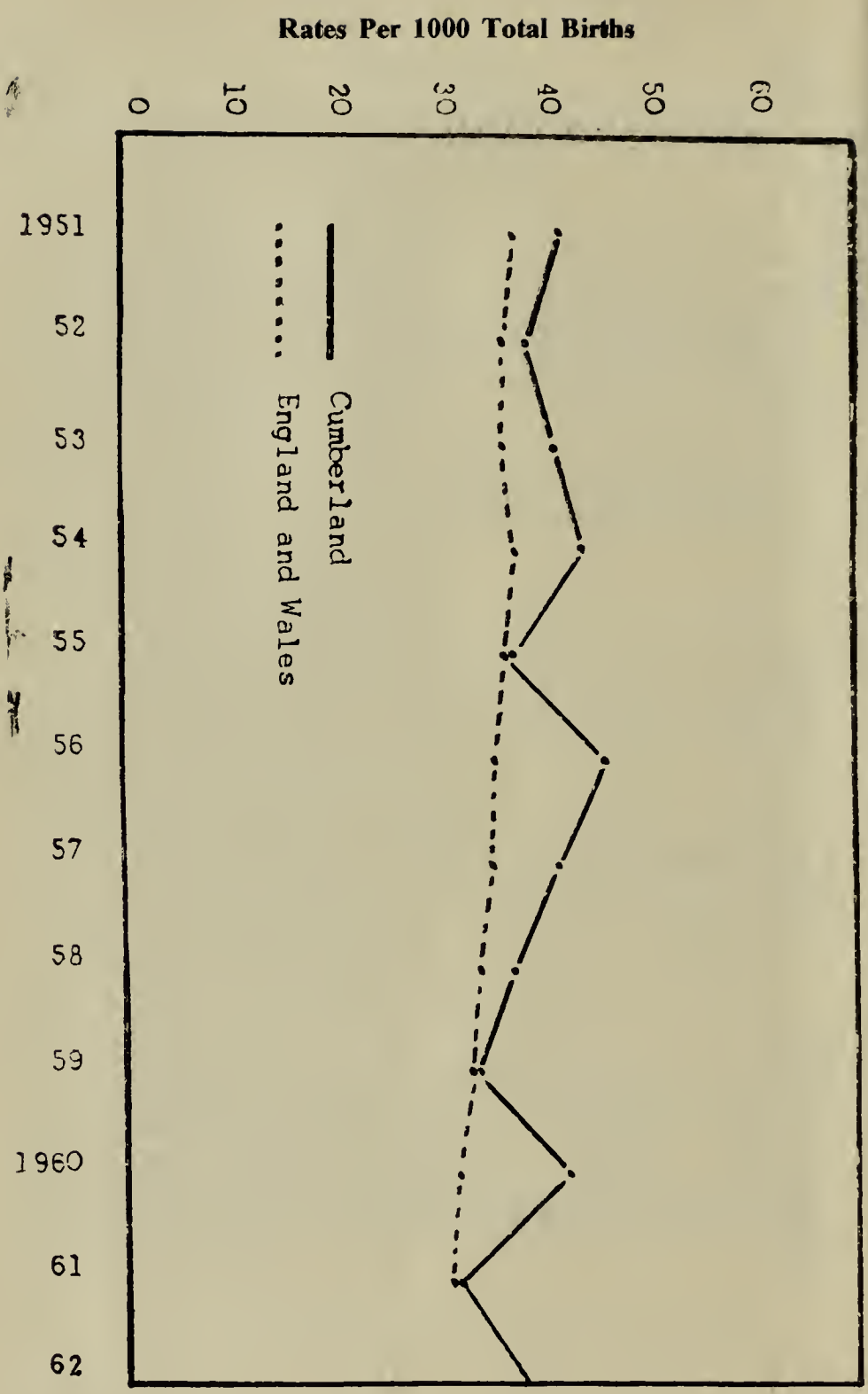
Perinatal Mortality

The number of still births and 1st week infant deaths per 1,000 live and still births—the perinatal mortality rate—was 35.8 for Cumberland in 1962. The corresponding national figure is not yet available, but, following the steady trend over the year, should be in the region of 32. I have shown the perinatal mortality rate in graph form which indicates the rather irregular trend in Cumberland, one which is clearly much less satisfactory than the national. In my comments on the midwifery service I indicate quite clearly some of the factors which I cannot but associate with this high perinatal mortality rate. It can only continue to be regarded with anxiety at the present level.

It is of considerable interest, however, to note the difference in this respect between East and West Cumberland. The east part of the county, containing approximately 1/3rd of the total population, has a rate of 42.4, while the rate for West Cumberland is significantly lower at 32.6. The ratio of hospital: home confinements was the same for both areas, viz., 72:28. In an attempt to pin-point factors of significance in perinatal deaths in 1962 occurring in domiciliary confinements in East Cumberland, the 11 of these which took place were analysed in the department and discussed fully at the East Cumberland Local Maternity Liaison Committee. Arising out of this, points of detail of the midwives' records were discussed with them at subsequent meetings, and at least 3 of the 11 cases should clearly not have been confined at home at all.

A Sub-Committee of the West Cumberland Local Maternity Liaison Committee has been studying all perinatal deaths occurring in West Cumberland during 1962, seeking to assess all the factors which might have a bearing on each case. Domiciliary midwives and general practitioners have been co-operating in this study whose analysis is not yet complete.

Year	Stillbirths	Early Neonatal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1951 ...	101	56	157	26.7	23.0	41.5	38.1
1952 ...	94	55	149	25.0	22.7	39.1	37.5
1953 ...	99	54	153	27.0	22.4	41.3	37.0
1954 ...	106	53	159	29.8	23.5	43.7	38.1
1955 ...	79	61	140	21.7	23.2	38.5	37.6
1956 ...	111	64	175	29.3	23.0	46.2	36.8
1957 ...	102	64	166	25.5	22.4	41.5	36.2
1958 ...	80	69	149	20.4	21.6	38.1	35.1
1959 ...	83	54	137	20.9	20.7	34.5	34.2
1960 ...	111	60	171	27.4	19.7	42.2	32.9
1961 ...	76	53	129	19.3	18.7	32.4	32.2
1962 ...	78	71	149	18.7	18.1	35.8	—



COMPARISON OF PERINATAL RATES, 1951-1962

Analysis of Causes of 149 Perinatal Deaths during 1962

Cause of Death		Stillbirths		Deaths during	
		Premature	Full-time	1st Week	Total
Toxaemia	...	1	2	—	3
Antepartum Haemorrhage	...	5	4	—	9
Placental Insufficiency	...	5	7	—	12
Rh. with Antibodies	...	3	1	2	6
Prematurity	...	—	—	27	27
Congenital Malformation	...	20	5	9	34
Asphyxia—		—	—	4	4
(1) Prolapse of Cord	...	1	1	—	2
(2) Cord around neck	...	—	1	—	1
(3) Intra Uterine	...	—	7	—	7
Difficult labour with breech delivery	...	1	—	—	1
Intestinal obstruction and infection	...	—	—	1	1
Atalectasis	...	—	1	11	12
Pneumonia and Bronchitis	...	—	—	3	3
Congenital heart disease	...	—	—	4	4
Cerebral Haemorrhage	...	—	4	7	11
Virus infection in mother	...	—	2	—	2
Maternal death	...	1	—	—	1
Cerebral Anoxia	...	—	—	1	1
Renal Vein Thrombosis	...	—	—	1	1
Adrenal Haemorrhage	...	—	—	1	1
Prem. Separation of Placenta	...	2	—	—	2
No known cause	...	2	2	—	4
		41	37	71	149

Infant Mortality

Cause of Death	Age in Weeks			
	Under 1	1 to 4	4 to 52	Total
Rh. with Antibodies ...	2	—	—	2
Prematurity ...	27	2	—	29
Congenital Malformation ...	9	5	—	14
Anoxia ...	1	—	—	1
Asphyxia ...	4	—	—	4
Asphyxia due to inhalation of vomit ...	—	1	4	5
Intestinal obstruction and infection ...	1	—	—	1
Atalectasis ...	11	—	—	11
Pneumonia and bronchitis ...	3	1	11	15
Congenital heart disease ...	4	2	4	10
Leukaemia ...	—	—	1	1
Cerebral Haemorrhage ...	7	—	—	7
Nephritis ...	—	—	1	1
Meningitis ...	—	1	1	2
Gastro Interitis ...	—	—	1	1
Biliary Peritonitis ...	—	—	1	1
Bronchiectasis ...	—	—	1	1
Renal Vein Thrombosis ...	1	—	—	1
Adrenal Haemorrhage ...	1	—	—	1
	71	12	25	108

The comparative rates of infant deaths per 1000 total live births for Cumberland together with England and Wales are as follows for the period 1952-62:—

Year	Rates per 1,000 total live births	
	Cumberland	England and Wales
1952 ...	32	27.6
1953 ...	27	26.8
1954 ...	27.6	25.4
1955 ...	28.4	24.9
1956 ...	30.4	23.7
1957 ...	26.4	23.1
1958 ...	28.2	22.5
1959 ...	21.1	22.2
1960 ...	23.1	21.7
1961 ...	22.6	21.6
1962 ...	26.4	21.4

Prematurity

It will be seen from the table on premature live births that there were 83 babies born in hospital in the two lower weight categories A and B, that is up to and including 4 lbs. 6 ozs. This was an increase on the 1961 figure of 24, or over 40 per cent. Amongst these two groups during 1961, 62 per cent. of the total born survived 28 days or more, whereas only 50 per cent. survived in 1962.

The cause for the increase of premature infants in these two lower weight categories is not apparent, but although the total premature live births for the year is more or less the same compared with the previous year, there are in fact more infants who did not survive. This is because of the high number in the lower weight categories where the chance of survival is less.

Of a total of 27 live born premature infants which occurred at home and were nursed entirely at home only one infant died within 28 days.

Unmarried Mothers

The arrangements for the care of unmarried mothers made in association with the Carlisle Diocesan Council for Social and Moral Welfare and the Lancaster Diocesan Protection and Rescue Society, continued to operate.

During the year 38 cases were approved for maintenance at Coledale Hall, Carlisle; St. Monica and Brettargh Holt at Kendal and the Salvation Army Home, "Hopedene", Newcastle. The average length of stay after confinement at Coledale Hall was 28 days, Brettargh Holt 42 days and other establishments 45 days.

The age groups of the 28 cases are shown in the following table together with comparable figures for the previous years, from which it will be seen that the year 1962 shows a slight increase on the previous year.

Age	1962	1961	1960	1959	1958	1957
13 ...	—	—	1	—	—	—
14 ...	2	—	—	—	—	1
15 ...	3	1	1	1	—	—
16 ...	5	3	3	3	1	1
17 ...	4	5	3	4	2	3
18 ...	7	2	3	6	5	5
19—24 ...	12	22	20	16	15	15
25—30 ...	4	1	10	5	5	9
31 and over ...	1	1	3	2	—	4
Total ...	38	35	44	37	28	38

Premature Live Births

PREMATURE STILL-BIRTHS.

Weight at Birth.	Born in Hospital.*			Born at home and nursed entirely at home.			Born at home and transferred to hospital on or before 28th day.			Born in Nursing Home and transferred to hospital on or before 28th day.					
	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total	Died within 24 hours of birth	Survived	Born in hospital.	Born at home.	Born in nursing home
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
(a) 3 lb. 4 oz. or less (1500 gms. or less) ...	35	23	8	—	—	—	5	2	1	—	—	—	19	3	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1500-2000 gms.) ...	48	10	34	2	1	1	5	—	4	—	—	—	7	2	—
(c) Over 4 lb. 6 ozs. up to and including 4 lb. 15 oz. (2000-2250 gms.) ...	28	1	25	2	—	2	2	—	2	—		—	8	—	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2250-2500 gms.) ...	91	2	86	23	—	23	5	—	5	1	—	—	3	1	1
TOTALS	202	36	153	27	1	26	17	2	12	1			37	6	1

Distribution of Welfare Foods

During the year some re-organisation of distribution points and centres was effected, so that at the end of the year distribution was carried out from 11 maternity and child welfare centres and from 91 other places, the latter in the main being undertaken on a voluntary basis by members of the W.V.S., who also co-operate in distribution to these points. As a result of the re-organisation seven points were closed in the rural areas where it was found that no positive demand existed.

The prices of the products remained the same throughout the whole year, but the consumption of the vitamin supplements continued to decrease. It is, however, encouraging to note that the distribution of National Dried Milk did not fall as had been the occasion in the previous five years.

Total issues to beneficiaries and hospitals

	National Dried Milk	Cod Liver Oil	Vitamin Tablets	Orange Juice
1955	... 145696	25082	6413	113548
1956	... 151101	23669	7274	124212
1957	... 128219	22517	6920	137336
1958	... 115685	15198	6338	89366
1959	... 105984	15350	7076	93684
1960	... 92676	14961	7450	90343
1961	... 78155	9067	5017	50653
1962	... 79446	4712	2669	31964

Dental Services

The Chief Dental Officer makes the following comments on the dental services for 1962:—

Although more sessions were devoted to the dental treatment of Maternity and Child Welfare patients, there is still room for improvement, particularly in the educational field. The efforts of the Dental Officers to encourage expectant and nursing mothers to accept treatment, combined with their technical skill and understanding of the patient, is certainly attracting more patients to the clinics. Great progress is also being made with the treatment of the "under fives".

In certain areas of the County the number of patients seeking treatment in the clinics run by the Local Authority is very high, and, in one area, despite the fact that there are many private practitioners in the town, there is a particularly large acceptance rate which is entirely due to the enthusiasm of the Health Visitors and their co-operation with the dental staff at the clinic. Unfortunately there are many Health Visitors, Midwives and District Nurses who do not use their opportunities in dealing with maternity patients to suggest that treatment may be necessary or that it may be obtained at the County Clinics.

It is now proposed to send an attractive birthday card to all children on their third birthday and, at the same time, suggest to their parents that they take the child to the nearest clinic for a dental examination and, if necessary, treatment.

The annual returns of work done show that far more fillings and far fewer extractions are being done on the pre-school children and one sincerely hopes that this most satisfactory state of affairs will continue. As has been stated many times, the best assessment of the clinical picture from the statistical returns is the relationship between the number of fillings and the number of extractions.

Now that so much progress has been made with the fluoridation projects one can confidently expect to see very little dental decay in the mouths of the children of future generations due to the most marked resistance to acid destruction which the addition of fluorides to our water supplies produces; but oral hygiene will always be a matter of great importance, and still further efforts must be made to instruct both parents and children in this matter.

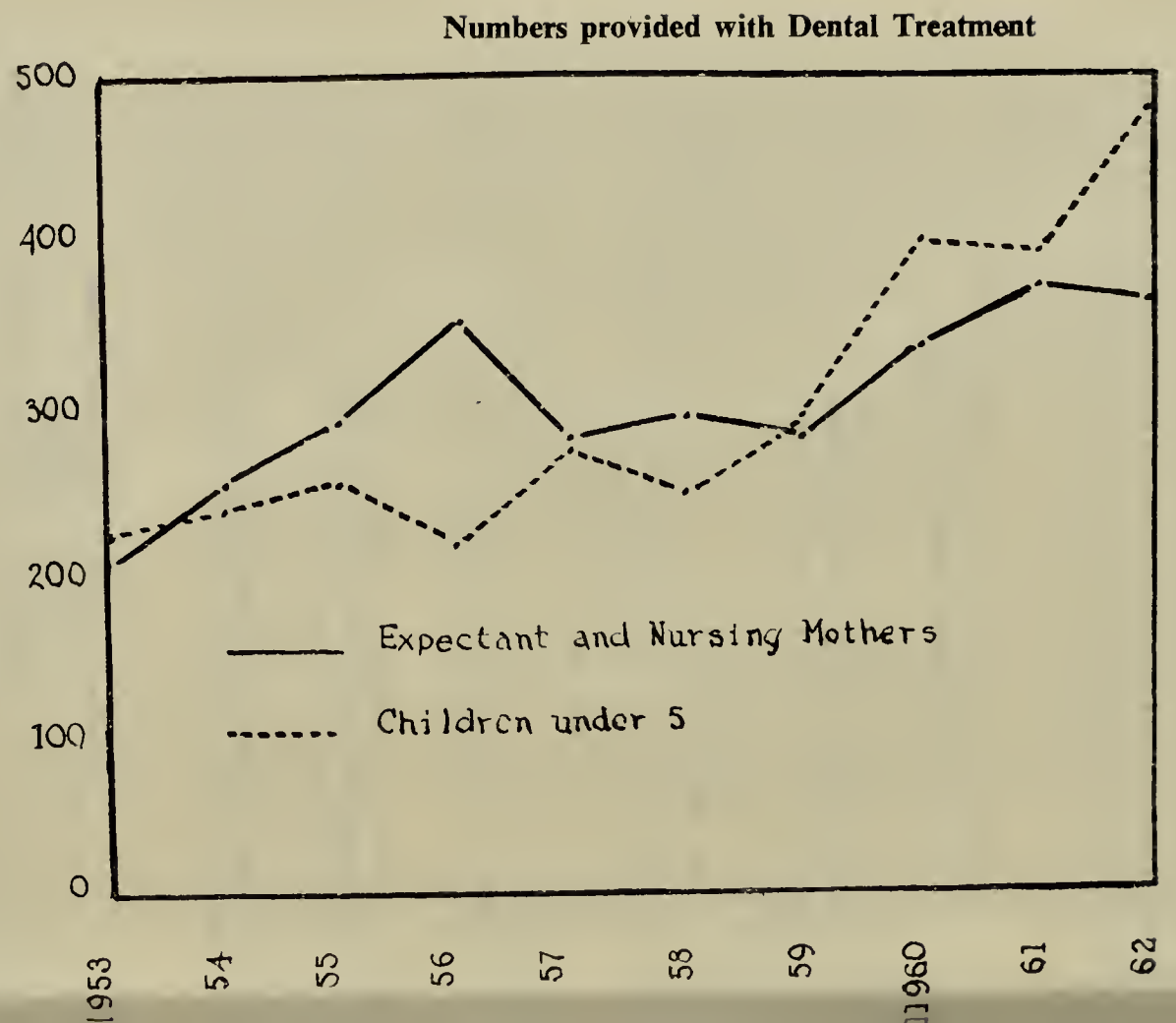
May one make a special plea to ban the "Dinky Dummy"? This miniature feeding bottle with a teat end is filled with vitamin syrup or sweetened fruit juice and then the infant sucks this contentedly for hours but, at the same time, keeps is teeth bathed in sugar solution which does, in many cases, cause rampant decay. Many mothers use these dummies in all good faith, firmly believing that a constant supply of additional vitamins and sugar is of benefit to the child and do not realise the irreparable damage which is being done to the child's teeth.

Dental Care of Expectant and Nursing Mothers and Children under School Age

(a) Number of Officers employed at end of year on a salary basis in terms of whole-time officers to the maternity and child welfare service :—	
(1) Senior Dental Officer	0.06
(2) Dental Officers	0.6
(b) Number of Officers employed at end of year on a sessional basis in terms of whole-time officers to the maternity and child welfare service	—
(c) Number of dental clinics in operation at end of year	19
(d) Total number of sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during year	277
(e) Number of dental technicians employed in the Local Health Authority's own laboratories at the end of the year	2

Numbers provided with dental care

	Examined	Needing Treatment	Treated	Made Dentally Fit
Expectant and Nursing Mothers ...	425	425	365	265
Children under 5 ...	623	513	480	374


Numbers provided with Dental Treatment
500
400
300
200
100
0
Expectant and Nursing Mothers
Children under 5
1953
54
55
56
57
58
59
1960
61
62

Forms of Dental Treatment Provided

	Scalings and gum treatment	Fillings	Silver Nitrate treatment	Crowns or Inlays	Extractions	General Anaesthetics	Dentures Provided: Full Upper or Lower	Dentures Provided: Partial Upper or Lower	Radiographs
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Expectant and Nursing Mothers ...	47	304	—	6	1173	124	214	65	16
Children under 5 ...	23	211	69	—	729	242	—	—	9

Child Welfare Centres

The attendances at child welfare centres continues to rise and show an increase over the previous year of over 18 per cent. The number of children who attended the centres for the first time during the year is higher than it has been over the past ten years.

The centre in Carlisle which served the villages on the periphery was closed and in its place the Council opened clinics in the surrounding villages at Anthorn, Longtown, Scotby and Wetheral. By this arrangement the mothers can more readily obtain the services for which they previously had to travel a considerable journey. In addition a centre was opened at Thornhill to relieve the congestion at Egremont centre.

While all services provided at a clinic are also available through the hospital or Executive Council services, a close and continuous concern with the health and welfare of every child from conception to school leaving was something which neither of these services was designed to develop. This is a function of the local authority as Health, Welfare and Education authority: to provide a positive approach to the prevention of sickness and injury, to health education, training and the early ascertainment of weaknesses and deficiencies.

These services are being combined in a new clinic at Seascale in a particularly interesting way, where a clinic and library are being provided in one building, available to all members of the community, and thus becoming a focal point in the neighbourhood. The close association with the library service serves to underline the highly important health education content of the work of the clinic to-day. This clinic will be completed early in 1963.

While services for mothers and young children remain central in the use of the clinic premises, the comprehensive value of such a building, on a neighbourhood basis, should be readily apparent where Health and Welfare services are so closely integrated. It may well be that the problem of the future will be to accommodate, in the sessions available, the different services including the various groups of handicapped people in their widening activities.

A further thought which is being explored at the moment is how the General Practitioner might participate in the joint use of clinic premises, either through the adjacent building of his own premises or the possible rental of rooms in a County Council clinic for surgery purposes. There are many difficulties in the way of such an arrangement and it can only be said to be under consideration in a preliminary way at present.

Attendances at Child Welfare Clinics

Year	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children who first attended the centre during the year and who at their first attendance were under 1 year of age	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
				Under 1 year	1—2 years	2—5 years		
1954 ...	15	65	1347	933	1027	1181	3141	12794
1955 ...	15	58	1382	975	896	1103	1947	11734
1956 ...	15	59	1458	1053	922	964	2939	11912
1957 ...	18	69	1754	1310	1051	1056	3417	14452
1958 ...	19	88	1757	1326	1192	1225	3743	18061
1959 ...	22	92	2093	1596	1455	1389	4440	21947
1960 ...	22	95	2011	1548	1408	1368	4299	22089
1961 ...	23	95	2373	1603	1667	1704	4974	23004
1962 ...	27	96	2658	1894	1625	2080	5599	27299

Family Planning

The Family Planning Association held their clinics in the County Council premises at Park Lane, Workington, and Brunswick Square, Penrith, and the arrangements previously established continue to operate on a very satisfactory basis. Patients are seen by appointment.

Nurseries and Child Minders Regulation Act, 1948

There were no changes in the county under this regulation during the year, and the three establishments registered and approved by the authority provide places for 29 children.

Marriage Guidance Council

The Carlisle, Cumberland and Eden Valley Marriage Council was constituted in May, 1961, and each year since then the County Council has made a grant to assist with the work of this body. The Lord Bishop of Carlisle is President of the Council and the Chairman is a Conslutant Obstetrician and Gynaecologist. The aims of the Marriage Guidance Council are stated as the enlistment of the services of qualified men and women in the work of reconciliation and education for marriage; the provision of help for parents and young people; guidance and help about marriage, parenthood and family life; the counselling of those who find difficulties in married life and the overall promotion of family life and parenthood.

The achieving of these excellent objectives is mainly through the services of carefully selected and trained counsellors and through the development of educational work with Youth Clubs, senior school children and other youth organisations. There is no doubt that this latter work is of cardinal importance, and should form the natural complement to much of the health education carried out in the schools by the School Medical Officers and School Nurses as well as the not inconsiderable help that Health Visitors and Domiciliary Nurses and Midwives provide in the normal course of their daily duties.

A further step with regard to marriage guidance was made during 1962 with the establishment of a Catholic Advisory Council, also based in Carlisle with similar aims to the Carlisle, Cumberland and Eden Valley Marriage Guidance Council. The County Council also resolved to make a grant to this Council.

Child Welfare Survey

During the year Part I of a "Child Welfare Survey" was completed. The enquiry was fact finding, designed to obtain the mothers' views on the service provided; suggestions for improvement; reasons for non-attendance and irregular attendance and the community attitude to child welfare clinics. The survey, when fully completed, will I hope give an evaluation of the present use and future need of Child Welfare Centres in Cumberland.

The survey falls into three distinct parts:

Part I which I describe here was based on interviewing mothers at random clinics throughout the County. 500 mothers were interviewed, and to obviate any bias it was deemed advisable to employ "neutral" interviewers. In this respect I was very fortunate in obtaining the willing and enthusiastic help of the W.V.S.

Part II of the survey deals with those mothers who live within reasonable travelling distance of the clinic, but who have not attended for some considerable time. This part of the survey falls into two phases, firstly a letter to the mothers concerned asking them to state frankly why they have ceased attending and secondly follow-up visits will be made by the W.V.S. to those failing to reply.

The third part of the survey will be directed at obtaining a community attitude to Local Health Authority Clinics.

In Part I each mother was asked the following two groups of questions; Group A being chiefly concerned at analysing the thoughts of mothers about the service as it is at present, and in Group B more emphasis was placed on possibilities in further developments. The main findings are summarised beneath each question.

Group "A"

1. "Why did you first come to the clinic?"
   Approximately a quarter of the mothers interviewed gave baby weighing as the main reason for first attending the clinic. It is disturbing to find such prominence given to this aspect of child welfare work and further re-orientation of attitude to the functions of the modern clinic is clearly necessary.

2. " Do you attend frequently? "
If " No " please state why.
76 per cent. of the mothers claimed they attended regularly and this I think is quite satisfactory. The main reasons for infrequent attendance were " Only frequent with baby — not so with toddlers " and " only for injections ".

3. " What in your opinion are the **main** advantages of attending a child welfare clinic? "
50 per cent. thought that the main advantage of attending a clinic was for advice and re-assurance. This seems to indicate that attendances at clinics develop increasing awareness of the importance of the clinic's advisory function and a slight falling off in the prominence of baby weighing in mothers minds (20 per cent.).

4. " How can the service be improved? "
60 per cent. were satisfied with the present service, but suggestions were made concerning structural improvements, waiting time, appointment system, availability of welfare foods and clinics nearer home. The suggestions are being examined and already a satellite clinic has been opened at Thornhill.

Group " B "

1. " Would you like more group talks and discussions on health subjects? "
73 per cent. of the mothers are anxious to have more group talks and discussions particularly on general baby-care and childish ailments. This fits in with the present development of increasing group health education in clinics.

2. " Would you prefer the services which are provided at the clinic, including health visitor attendance, to be available from your own doctor at his surgery? "
17 per cent. only would prefer the service to be available from their own doctor at his surgery. The main theme that emerged from the replies at all centres was that a high proportion preferred the services to be available at a clinic. 91 mothers (18 per cent.), however, were only concerned with the nearness of the clinic or surgery.

3. " Have you ever sought advice at the clinic on a problem of your child's behaviour as distinct from his physical health? "

" If ' yes,' do you feel that you were really helped ? "

(**Note to Interviewer** — If mother tells you about a behaviour problem, please record it.)

93 per cent. of the mothers had never had to ask advice at the clinic on a problem of their child's behaviour. However, of those who sought advice 73 per cent. said they were helped. The main reasons for seeking advice were bed-wetting and feeding problems.

4. " Would a serial T.V. programme, showing a child's progress and development, be of benefit to you and your husband? "

88 per cent. thought that a T.V. programme showing a child's progress would be beneficial.

I hope to be able to publish the results of Part II and Part III of the survey in next year's Report.

SECTION 24

HEALTH VISITING

At the end of 1962 there were 24 whole-time health visitors which represents a full establishment. In the rural areas health visiting is undertaken as formerly by 37 district nurses who are doing the combined work of general nursing, midwifery and health visiting, 16 of whom already hold the health visitor's certificate. The remainder are employed in a temporary arrangement by dispensation from the Ministry of Health.

During the year the health visitors have made 26,126 visits to children under 1 year of age and 29,219 visits to children aged 1-5 years. There is a decrease in these figures from the previous year and the continuation of selective visiting probably accounts for this. A substantial increase shows in other cases—this has risen from 3,195 in 1958 to 7,259 in 1962—mainly accounted for by visits to old persons.

Health Visiting

Year	Number of Children under 5 years of age visited during year	Children under 1 year of age		Children age 1 but under 5 years
		First Visit	Total Visits	Total Visits
1958 ...	17085	4640	28615	33519
1959 ...	17993	5438	32061	35053
1960 ...	18404	4054	27775	34511
1961 ...	18170	4172	29972	32113
1962 ...	18841	4176	26126	29219

The three students who took their health visitor training during the year completed the course and passed the examination. Two are working in rural areas and one is a full-time health visitor working in an urban area. Three more students have been accepted for training, all of whom will eventually work in rural areas of the county.

There is provision in the estimates for four scholarships each year. Unfortunately only three applicants have proved suitable in the last two years. It is hoped the scholarship scheme and the

appointment of fully qualified district nurse/midwife/health visitors to the rural areas will eliminate the need to seek dispensation for staff at present undertaking the work.

During the year two health visitors attended a course on the Principles and Practise of Health Education at Bolton Technical College. Two others attended the residential Autumn School at Bedford College, which included sister tutors from the hospital service. They found this course very stimulatiing as it gave each side the opportunity of discussion and learning from each other. Subjects included Health Education in the Community and in Hospital, the Place of Health Education in the promotion of Mental Health, and Education for Rehabilitation. Two of the health visitors practising in the rural areas attended a residential course at the William Rathbone Staff College. This course included the Principles of Teaching, Human Relationships and Working together in the Health Service. As these nurses frequently have student health visitors they found the course, although very short, useful and stimulating.

In April we welcomed 13 students from the Bolton Technical College Health Visitors' Course. They spent a week in the county having experience of work in rural areas. Again many of the students stayed with the nurses in their own homes, where they offer them true Cumberland hospitality and enjoy the link with the Health Visitor Training Course which keeps them in line with the training syllabus and present trends.

Hospital Liaison

The two Assistant Nursing Officers in West Cumberland have continued to visit the geriatric unit at the West Cumberland Hospital each week and have been able to discuss the after care of the patients on discharge from hospital with the physician, almoner and nursing staff. Some of the health visitors have also taken part in this work and have appreciated the co-operation of the hospitals. They also visit the maternity units in the county and the children's ward at Workington Infirmary. The Assistant Superintendent Nursing Officers in West Cumberland comment as follows:—" This liaison is invaluable, the hospital staff informing us of the capabilities of the patients to be discharged and of the appliances and help needed. Advice on nutritional requirements as established during a hospital stay is an example of the helpful guidance which can be passed on to the local authority staff on a patient's discharge. Such information aids us in our assessment of those who need priority for meals on wheels, or provision of a meal by the home help when the patient is discharged.

Our knowledge of the background and social situation of patients is helpful to the hospital staff, and we have the opportunity during discussion of bringing to the notice of the clinician the social conditions of those awaiting admission so that any special factors can be taken into consideration.

In spite of our very good relationships it can happen that patients are discharged without prior notification to us and this results in a district nurse or home help not being available at the time of the patient's return to home. This is possibly associated in some cases with arrangements for communication between almoner and family doctor rather than a disregard of the services available.

The weekly visits are of value to us; we are aware of the problem arising in hospital and are kept up-to-date with new treatments; we enjoy the contact with our hospital colleagues."

Secondment of Health Visitors to General Practices

Since reporting quite fully on this subject in my last annual report, a further four full-time health visitors have been seconded to general practices. This means that there are now 17 of the 24 full-time health visitors so attached, none of whom have any doubts with regard to the advantages of secondment.

The greater part of the scheme has been most gratifying and successful, and I would like to quote some of the doctors who have provided me with a frank and I must say most encouraging commentary on their experience. One doctor writes as follows:—

" The health visitor seconded to this area has been of the utmost help and a great success. I feel that I have not yet fully learned how to benefit from her presence but no doubt this will come in time."

Another general practitioner writes as follows:—

" I am extremely pleased to tell you that Miss ———— is a tremendous asset to this practice. Her common sense and good will have been of extreme value in helping us treat both the young children and the aged and I might say that our work has been considerably reduced by her help. She is always willing to give of her best. All in all I think that her coming to us has been a tremendous boon and I am certain will continue to be so."

Both of these opinions were relatively early in the experience of the doctors concerned, but I know that their opinions have been fully justified.

The health visitor whose services have so impressed these doctors, herself gives the following account of her work:—

" I visit daily when possible, and the following illustrates the type of visit I am asked to undertake:—

(1) A mother suddenly taken into hospital requiring a link up of services for the care of the children.

(2) The visiting of children with infectious diseases.

(3) Feeding problems in young children.

(4) Threatened suicide case of mother with 4 year old child.

(5) Care of elderly husband left alone while his wife was admitted to hospital—arrangement of home help services, etc.

(6) Early receipt of information about husband with malignant disease, giving an opportunity to support and advise mother with young family.

My own views are that it is very difficult for health visitors to work without close links with general practitioners and I believe that the patients appreciate knowing that the health visitor and their own doctor work together."

One of the practices which has now had two full years experience of secondment confirmed, " that we as a practice continue to find the liaison between ourselves and the health visitor a success, particularly in the care of the aged, and in rounding up children for vaccination and immunisation ".

It will be appreciated that in a rural county certain of the full-time health visitors cover a wide area geographically, and their secondment to general practitioners does not allow of the same frequency of contact. In one such case the health visitor reports:

" I have continued visiting Dr. ———— surgery at least once weekly and have been asked to help in visiting old people regarding home helps and housing problems. Usually I go if possible on Wednesday mornings when Dr. ———— has a session for vaccination and immunisation after his normal morning surgery. I think the arrangement is working very satisfactorily now."

As is to be expected in such a scheme, the pattern of working varies quite considerably as between one practice and another, both in the matter of the frequency of contact between health visitor and doctor and in the volume and type of work requested. It would be surprising if the health visitors involved in this scheme were uniformly enthusiastic about their acceptance and usefulness to the doctors: nor can all of the doctors concerned be said to show as full an appreciation as may be of the potentialities of the

scheme. This aspect of the matter is well illustrated by comments of one health visitor who is attached to a practice of four doctors, and although there is one of them whom she seldom sees, the other three co-operate well and one of them has written as follows:—

"I have found the scheme of seconding health visitors to the practice a useful one. The health visitors have helped—

(1) To encourage attendances to complete courses of treatment (immunisations, blood checks, etc.).

(2) To supervise infant feeding and report back.

(3) To try to improve standards of cleanliness in certain homes.

(4) Arrange home helps, meals on wheels, chairs, etc.

(5) To find out details of poliomyelitis immunisation in pregnant women, mainly of those cases who have had incomplete courses at various centres."

Another health visitor who is now in her second year of secondment reports progress present but somewhat slow in terms of the full realisation of the potential advantages of secondment. She speaks of instances where she might have been helpful but had not in fact been brought fully into the picture. Even in such a case, however, the closer attachment to the general picture is readily acknowledged as being a major advance on the older arrangement providing minimal contact with the general practitioners.

It is very significant I think that many of the health visitors reporting this year have come so much to take their seconded relationship with the general practitioners for granted that they find it a little more difficult to give a colourful account of the working. Last year this was something new and often quite strikingly in contrast with the previous pattern of work. Now it is normal and it requires an effort to recall the disadvantages of the past which have been shed.

There is no doubt that secondment to general practices has made the health visitors into extremely busy people, but the arrangement is working and on the whole working very well indeed. Any doubts with regard to the wisdom of secondment have progressively receded and this has been in no small measure due to the enthusiastic co-operation of a splendid band of health visitors.

It should also be kept in mind that while I have only spoken of secondment in relation to full time health visitors, there are in fact 37 nurses in the county who perform health visiting duties in

conjunction with district nursing and/or domiciliary midwifery. In a large number of these cases of course the nurse is in close and regular contact with the general practitioners with whom she works on various counts each week, and liaison in these cases with regard to health visiting duties as well as nursing and midwifery, has always been close and frequent.

Group Meetings

During the year health visitors meetings have been held on four occasions and among the subjects discussed have been the Child Welfare Clinic Survey, At Risk register and selective school medical examinations. In addition a number of group meetings have been held at which the district nurses, midwives and health visitors met together and discussed the problems in their areas. Film strips and films have been shown.

In Service Training — Mental Health

As many of the health visitors had taken their training many years ago at a time when mental health work was not included in the syllabus it was decided, in order to bring the nurses training up-to-date, that they should spend two weeks at Garlands Hospital observing the care of the patients and the new treatments. This scheme commenced in November and in the new year arrangements will be made for some health visitors to attend psychiatric out-patient clinics and the new psychiatric unit in West Cumberland. Some interesting reports have been received. For example:

> "I found my two weeks observation at Garlands Hospital most interesting and enlightening, and came away with the impression that all nurses would benefit from a similar experience. Conditions were entirely different to what I had expected."
>
> "It was most interesting to see the early stages of mental illness at the new clinic, and the effect of the new drugs and treatments given. We were able to see electro-convulsive treatment given and noted, especially with the use of Scoline, how completely relaxed the patients were before the shock was given, and how quickly they recovered and were up and about again."
>
> "The effect of these new drugs was quite astonishing and also the fact that a patient who has had a certain type of mental illness can go through life without relapse on as little as half a tablet once a day for the rest of his life. There

seems to be quite a need to educate the public about this. So many people with good intentions try to persuade patients that they should pull themselves together and do without their pills after a certain length of time."

Some of the health visitors have found among the patients those whom they knew from their own areas, and were particularly pleased to be able to talk to them. They feel that they can now speak confidently of the treatment given and re-assure patients who may have to be admitted to a mental hospital.

We are very grateful to the Medical Superintendent, Consultant Psychiatrists, Matron and staff of Garlands Hospital for their help and co-operation in this field.

SECTION 25

HOME NURSING

" It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes."

It is interesting to consider how the exercise of this responsibility has been affected over the years by the many changes in the face of medicine. The actual manpower of the service has not varied much since the nurses serving the then Cumberland Nursing Association were taken in 1949 into the direct employment of the County Council. The earliest antibiotics were coming into their own by then, and although these allowed more heavy nursing cases, e.g., pneumonia, to be retained at home, they also cut down the period of acute illness which demanded so much skilled nursing time. Death rates from infections began to decline and the degenerative diseases associated with ageing to take their place. Throughout this changing pattern of work the home nurses close day by day ties with the general practitioners have remained fundamental to the value of their work. For several years the weight of work has been increasingly moving towards the increasing elderly population—a trend which can only be expected to continue—although the total cases nursed and the total nursing visits have continued the slightly downward trend of recent years.

Perhaps the most significant pointer for the future is in terms of increasing liaison with hospitals and general practitioners towards a more comprehensive cover of the nursing needs, both of those awaiting admission to hospital and those discharged back to their own homes. Circular 15/62 underlined the need for effective mobilisation of domiciliary services especially for cases awaiting hospital admission, and led to a closer link between the Assistant Superintendent Nursing Officers in West Cumberland and the hospital wards, especially the geriatric wards, and the Hospital Almoners. At the time of writing this report Circular 3/63 has just been received, which carries further the matter of liaison suggesting specifically designated officers by Local Authorities and Hospitals so that lines of communication will be clearer and in most cases the home nurse should be in a position to ensure that a prepared home awaits a discharged convalescent as well as to serve the interim nursing needs of more waiting list cases.

At the 31st December, 1962, there were 58 Queen's Nurses, 8 State Registered Nurses, and 11 State Enrolled Nurses who were also State Certified Midwives, undertaking general nursing, of whom 15 were employed whole-time and the remainder combined general nursing with other duties.

	No. of cases nursed
Medical	4042
Surgical	1422
Tuberculosis	86
Infectious Diseases	15
Maternal Complications	70
Others	61
	5696
Number of nursing visits paid	111830
Number of casual visits paid	5818
	117648

It is of interest to compare the home nursing figures for 1962 with those of the previous years.

No. of Cases Nursed

	1955	1956	1957	1958	1959	1960	1961	19
Medical ...	5371	5178	5444	4946	5297	4982	4564	40
Surgical ...	2575	2316	1935	1897	2002	1806	1488	14
Infectious Diseases ...	28	13	16	12	16	8	6	
Tuberculosis ...	316	189	250	250	171	114	164	
Maternal Complications	71	94	112	85	69	59	42	
Others ...	30	35	24	88	219	103	111	
	8391	7825	7781	7278	7774	7072	6375	56

Analysis of Cases Nursed

		Percentage of total cases nursed
No. of cases nursed over 65 years of age ...	2893	51%
No. of cases of malignant disease	237	4%
No. of children nursed under 5 years of age ...	381	7%
Remaining cases	2185	38%
	5696	

No. of Nursing Visits to above Cases

	1955	1956	1957	1958	1959	1960	1961	1962
al ...	87983	86372	99007	97337	94437	91855	92963	86697
al ...	35962	29907	29265	30073	28724	23639	20658	20693
ious cases ...	581	84	67	81	52	81	125	107
culosis ...	8859	5289	6171	5886	4149	4132	3432	2515
nal mplications	161	570	845	629	642	504	331	453
s ...	212	715	131	237	609	815	3741	1365
l Visits ...	4782	5771	6493	3656	7151	6570	6360	5818
	138540	128708	141979	137899	135764	127596	127610	117648

Analysis of Nursing Visits

		Percentage of total nursing visits paid
Total number of nursing visits to persons over 65 years of age	69442	59%
Total number of nursing visits to children under 5 years of age	2341	2%

There is a decrease in the number of cases nursed and the total number of visits paid. The number of visits paid to persons over 65 years has increased by 3 per cent. On the other hand, the volume of work in nursing visits to children under the age of five shows both an absolute and relative decrease this year. This I find a little disquieting in view of the well recognised advantages, both in terms of infection and of psychological effects when children are nursed at home as far as possible. I should hope that a trend is not appearing in this group of cases.

In certain areas of the county there were acute shortages of staff over the first half of the year, and this may well have contributed in some degree to the decrease in the volume of home nursing work. It is pleasing to record, that by the end of the year this situation was resolved and the vacancies were at a minimum, there being only 3 in rural areas for a district nurse/midwife/health visitor.

In West Cumberland it became apparent that there were many heavy male patients. The Committee considered the appointment of two male Queen's nurses and in the autumn Mr. Blackburn and Mr. Holmes were appointed to Whitehaven and Workington respec-

tively. These appointments have been fully justified. Mr. Blackburn reports: "Since working in Whitehaven I have been very well received by both patients and relatives. I find that many male patients appreciate having a male nurse and they confide their personal worries, particularly the older patients. The female nurses and myself work well together. They may be visiting a male patient, who is ambulant, for a weekly injection, but later if he becomes ill and bedfast I take over. I have very good contacts with the family doctors and we meet for discussion. I would like to quote a particular case of a patient, aged 45, with two teenage children, who was very depressed after an abdominal operation and found great difficulty in making the adjustments necessary. However, with the encouragement and help of his wife he was slowly able to take up some of his old activities. He is now quite well and full of confidence, and will be returning to work shortly." In a report from Mr. Holmes he states: "I have found the work most interesting and have had a variety of patients to visit, including many with terminal illnesses. I have found my colleagues and general practitioners most helpful and co-operative and have been able to discuss many problems with them. I have very good contact with the staff in the geriatric ward in the West Cumberland Hospital; and we are able to discuss the patient's needs before he is discharged so that the relatives are ready to receive the patient and any necessary equipment is made available. I recently visited an elderly patient who had been in hospital for some time and whose personality had changed. A health visitor and myself visited the relatives and explained the situation and this enabled them to accept the patient's mental state. I have visited daily and the relatives are now much happier and willing to keep the patient at home, instead of insisting on his return to hospital."

The laundry service in Whitehaven is proving very useful to the households where there are very little or no facilities for drying sheets. The houses in the old part of the town have few facilities. It is an extremely useful service for old people living alone. During the year 16 sheets and 104 draw sheets were loaned and laundered through this scheme. The nurses and householders have found this service a great help. The wide use of incontinence pads alleviates the laundry situation in all the homes where it is necessary to use them, and the nurses state how invaluable they are and how much they are appreciated by the patients and relatives.

In May I was asked by the General Superintendent of the Queen's Institute of District Nursing to participate in district training for two students who were taking the course in Community Nursing arranged by Manchester University and Crumpsall Hospital. The Deputy General Superintendent visited Workington, the area where the training was to take place, and approved the arrangements made. Two students spent a month at Workington and worked under the supervision of the two Queen's Nurses. Following this the Health Committee sought approval to train a number of the present staff of district nurses who had worked in the county for many years but had been unable for domestic reasons to leave home to take the three months' district training. The scheme allows the students to take the practical course in their own districts and the three weeks' block period in one of the Queen's Training Homes. The Deputy Superintendent Nursing Officer was approved to act as tutor in the county. Approval was given to this scheme which will begin to operate in January, 1963. There are nine nurses on the staff who wish to take advantage of this way of training.

Thirty students from the Cumberland Infirmary, Whitehaven Hospital and Workington Infirmary have spent a morning on the district with the district nurses. This is of benefit to both the hospital and domiciliary service as it enables the students in training to get an insight into the work of the district nursing service and to appreciate the home conditions of their patients. On the other hand it is stimulating to the district nurses to keep in touch with the students in training.

Arrangements have been made with the Superintendents of the Queen's Training Homes at Gateshead, Salford, Stockport and Warrington, to take their students for three days rural experience, and during 1962 16 such students came to the County. The district nurses in the rural areas are always most helpful and assist the students in every way they can.

Refresher courses for district nurses were held at Durham University, Manchester University and William Rathbone Staff College, Liverpool, and were attended by eight district nurses.

Staff meetings are held every three months at Carlisle and Whitehaven. It is usual to arrange a lecture or film show on some topical subject: for example, during 1962 films were shown on "Phenylketonuria", "Sex Education", "Smoking and Lung Cancer", and "Help for the Disabled", and there is also a discussion on all aspects of the work.

Small group meetings are held two or three times a year so that the nurses in an area can meet, and this year such problems as the changing pattern of domiciliary nursing, selection of cases for hospital confinements, and the adoption of sterile syringes were discussed. This makes for a very good liaison between all the staff—health visitors, midwives and district nurses.

During the year the home teachers for the blind have been invited to the group discussion, and have given an account of their work. The Superintendent Nursing Officer or her Deputy are present at all staff meetings, whatever the topic under discussion, and at most of these I, or my Deputy, attended, and discussed fully with the Nursing staff current trends of thought in various aspects of their work. The principal departmental exercise of the year, namely, the preparation of a ten year programme for all services, served to provide an excellent back-drop for the discussion of the fundamental nature and content of the nurses' work in the future.

Towards the end of the year it was decided that the district nurses would be supplied with disposable equipment, which would include syringes, needles, masks, gloves and polythene sheeting in place of mackintosh sheeting. They much appreciate this labour saving equipment which relieves them of sterilising in the homes and the daily washing of masks which can be time consuming.

SECTION 26

Immunisation and Vaccination

During 1962 the immunisation and vaccination programme continued on the same pattern as previous years. There has been a slight amendment to Schedule P. which was set out in last year's report, following receipt of Ministry of Health Circular 27/62 on "Vaccination against Smallpox". This recommended that the offer of routine vaccination should preferably be made "during the second year of life", rather than at four to five months.

The Minister of Health in Circular 17/62 asked every local health authority to make a comprehensive plan for reaching and maintaining in its area as high a level of vaccination and immunisation as possible. A table was enclosed showing the various percentages of persons vaccinated against certain diseases. In order to comply with the Minister's request, a review was made of the immunisation and vaccination figures in the county. It appeared that the principal long term measure which seemed to hold out the greatest promise of improving the figures, was a steady increase in attendances at child welfare clinics, and efforts to achieve this were already under way. Another long term factor in securing higher immunisation rates against poliomyelitis is the secondment of health visitors to the practices of general practitioners.

With regard to the immunisation programme in schools, increasing use has been made during the year of disposable syringes, and this has meant that more schools can be visited in one session than was previously the case. Five or six small schools can usually be fitted in on one round of visits and this had become especially important since the introduction of primary courses of tetanus, where three visits to a school are necessary instead of one.

(a) Diphtheria Immunisation

The following table sets out the total number of immunisations against diphtheria carried out during the past ten years, and it is gratifying to note that the downward trend in evidence during 1961 has been halted. Whilst the figure of 7132 immunisations is not up to the 1960 figure, nevertheless it has been achieved in spite of two vacancies on the medical staff during the last quarter of the year, and as such is encouraging.

1953	6658
1954	6880
1955	9463
1956	5221
1957	7127
1958	4024
1959	5077
1960	8245
1961	5222
1962	7132

The figure of 7,132 can be broken down as follows:—

Primary courses	3449
Reinforcing injections	3683
	7132

85 per cent. of the primary courses were in respect of pre-school children, and the remaining 15 per cent. school children.

In past reports a table has shown the immunity index of children in the various age groups as a percentage of the group fully immunised at any time during the past five years. At the end of 1961 we were informed that this index would in future be calculated by the Statistics Branch of the Ministry of Health. This change was made to ensure that all calculations would be made on the same basis. The index for the past two years is as follows (1962 fig., local calculation):—

Year	Age 0 — 4	Age 0 — 14
1961	61	48
1962	61	50

Once again, no case of diphtheria occurred during the year, but the fact that only half the children under the age of 15 can be considered fully protected against the disease is a very disquieting one indeed. The avoidance of outbreaks of diphtheria in future is entirely dependent upon the maintenance of a high immunity index, and this cannot be too strongly emphasised. All doctors and health visitors have been asked to give this matter particular and continuing attention.

(b) **Whooping Cough Immunisation**

The number of children who have completed a primary course of whooping cough immunisation during 1962 was 2,890.

The following table shows the number of notifications of whooping cough over the past five years.

1958	28
1959	153
1960	392
1961	72
1962	39

(c) **Tetanus Immunisation**

The practice of offering tetanus immunisation to children in the county clinics and schools continued during 1962 and details of all children immunised were forwarded to the casualty surgeons in East and West Cumberland, in order that their registers could be kept up to date. A request was received from the Cumberland Local Medical Committee that all general practitioners should be informed if any of their patients were immunised in county council clinics, or schools, and a meeting was held on 9th May to discuss this. As a result, it was decided to keep general practitioners informed of any such injections given to their patients, and it was assumed that, if a tetanus injection was given by a general practitioner, he would keep his own record of this.

At the end of the year, 3,122 notifications had been sent to general practitioners. The number of children receiving a primary course of injections against tetanus was 5,342 and 1,173 were given a reinforcing injection.

(d) **Smallpox Vaccination**

During the year 2,150 children under one year of age received primary vaccination—a take-up rate of 52 per cent. In addition, 1,792 persons received primary vaccination and 796 were re-vaccinated. Owing to the occurrence of several cases of smallpox at the beginning of the year, members of the public became rather concerned and requests for vaccination, particularly from adults, became numerous. An appeal was therefore made to the public not to request vaccination as no scheme of mass vaccination was contemplated, and it was pointed out that primary vaccination of adults could be dangerous. There is no doubt that but for this appeal the number of vaccinations carried out would have been much higher.

In Circular 27/62, dated 16th November, 1962, local health authorities were advised that the Standing Medical Advisory Committee of the Ministry of Health had recommended that routine vaccination should be carried out during the second year of life, instead of the previous age of four to five months.

(e) **Poliomyelitis Vaccination**

The highlight of the year, so far as the poliomyelitis vaccination programme was concerned, was the issue of oral vaccine by the Ministry of Health in February. This new vaccine has been welcomed and accepted as an easier and more convenient method of vaccination than by injection, although Salk Vaccine was still being requested by a limited number of general practitioners.

On receipt of the oral vaccine it was necessary to rent two cold storage containers from a local firm, one being used at Carlisle and the other at Whitehaven. This storage problem was facilitated by the issue, later in the year, of a new stabilised vaccine which could be stored in a domestic refrigerator.

The practice of offering a fourth dose of vaccine to all children aged 5-12 years was continued, but owing to the time involved, this work was done in the clinics and medical officers did not make special visits to schools. At the end of the year 20,699 children had received a fourth dose and 56 per cent. of children aged 1-4 had received 3 injections or doses of vaccine, while a further 17.5 per cent. had received 2 injections. The percentage of school children who had received either 3 or 4 injections/doses was 92 per cent. with 7 per cent. receiving 2 injections.

The following table shows the figures by age groups for 1962 and the preceding four years.

Poliomyelitis Vaccination 1962

Total number of persons vaccinated :—

Age Group	Received four injections/ doses	Received three injections/ doses	Received two injections	Total
ildren and young persons born in years 1943—1962 ...	20699	33269	6838	60806
ung persons born in years 1933—1942 ...	—	12623	3123	15746
rsons born before 1933 who have not passed their 40th birthday ...	—	8996	1987	10983
thers ...	—	1563	454	2017
otal 31.12.62 ...	20699	56451	12402	89552
otal at 31.12.61 ...	15399	51746	16609	83754
otal at 31.12.60 ...	—	56883	14812	71695
otal at 31.12.59 ...	—	39297	23225	62522
otal at 31.12.58 ...	—	2294	44010	46304

It should be noted that the bulk of the children aged 5-12 years due for a fourth booster dose have now received this and the need for these fourth doses is not now quite so evident. The main aim should now be to ensure that as many persons under 40 as possible have received three injections or doses.

SECTION 27

AMBULANCE SERVICE

The year's highlight in the County Ambulance Service was undoubtedly the start to implement the policy decision that there should be a directly operated service to replace the contractual arrangements for ambulances and private hire cars for sitting case work. The "appointed day" for Phase I of the re-organisation was the 1st June and on that date all ambulance transport to cover the Border Rural, Penrith Urban and Penrith Rural districts and part of the North Westmorland area, were centralised in ambulance stations which were opened at Carlisle and Penrith. The vehicles were all fitted with radio, operating on the police frequency, and were controlled from the Penrith station. The radio reception has proved to be satisfactory and I am pleased to be able to say that the use of the police frequency has caused no difficulties either to the ambulance service or to the police.

The use of dual purpose vehicles enabled the use of all sitting case cars in the Northern and Eastern parts of the County to be dispensed with and has been responsible, to a large extent, for the decrease in the sitting case car mileage and the increase in the ambulance mileage shown in the statistical table which follows.

Plans have gone ahead for the second and third phases of the re-organisation and sites for ambulance stations at Wigton and Distington have been acquired.

It had originally been intended that because of the poor, indeed almost non-existent, radio reception in the area to the West of Wigton, it would be necessary to have a radio transmitter at the Wigton station. The intention was that the police would be able to share the facilities in return for the ambulance service's use of their facilities elsewhere. However during investigations by the Home Office wireless engineers it came to light that a transmitter site at Hazelshaw Hill, in Dumfriesshire, was becoming redundant and could be made available to the Cumberland and Westmorland Police. Tests showed that there would be adequate coverage from this transmitter and the plan has therefore been revised for the police to operate this transmitter and for the ambulance service to make use of the facilities instead of providing a transmitter at Wigton. This policy has the added advantage that it will be possible to control vehicles throughout the county from one centre if this is desired.

Towards the end of the year the Ambulance Adviser to the Ministry of Health came to Cumberland for a few days during which the re-organisation plans were discussed fully. Following these discussions and taking account of experience already gained in the direct service, it was thought advisable to change the plans for the service in West Cumberland. It had been thought earlier that a large station at about Distington would be able to cover the whole area adequately, but it has now been decided that it would be better to have a smaller station at Distington primarily to cover the Whitehaven and Workington areas and to give second-call night cover in other parts of West Cumberland. The other parts will be covered by satellite stations at or near Cockermouth, Maryport and Egremont, and each will have one ambulance and one dual purpose vehicle. These satellite stations will be operated under agency arrangements, but the vehicles, like all those in the directly operated service, will be controlled from the Distington station. The station at Millom will also be controlled from Distington but because of its isolation and the fact that the vehicles are for the most part running to hospitals outside Cumberland the station will to a large extent be self-controlled.

By making these changes it is expected to give better cover than might have been provided under the first scheme and is really a result of combining the best of the old with the best of the new. The stations at Wigton and Distington are scheduled to be built during the financial year 1963-64 and should therefore come into operation some time in 1964.

Although an Ambulance Liaison Committee for the area was in being, a meeting had not been called for two years. It was thought that there should be a meeting to discuss any matters which might have arisen out of the re-organisation of part of the Cumberland service and the meeting was attended by representatives from the Regional Office of the Ministry of Health, the hospital authorities and the ambulance authorities served by the hospitals in Carlisle,-Carlisle, Cumberland, Westmorland and Scottish Ambulance. Regular meetings are to be held in future. Among the matters of mutual interest which were discussed was the need for some scheme for the advanced first aid training of ambulance personnel. There have been further discussions on this subject and it seems probable that a training scheme will be inaugurated in the near future in which this county will participate.

During the course of the year oxygen equipment was installed in nine ambulances and further vehicles will be equipped during the coming year.

All vehicles continued to be inspected by the vehicle maintenance staff of the County Fire Service and any repairs which were recommended were carried out. Four old ambulances were replaced, one of them being given to St. John's Ambulance Brigade.

The following statistics for the year show that compared with 1961 there was an increase of 10,266 patients carried, but that this increased number of patients resulted in only 2,328 extra journeys and additional mileage of only 1,190 miles.

Although the direct service has only been in operation for seven months of the year, it is interesting to see the pattern of emergency calls. Of the 886 emergency calls received at the Carlisle and Penrith stations 120 were to road accidents, 26 were to accidents at work, 47 were to home accidents, 16 to accidents in public places, 3 to climbing accidents, 87 to maternity cases, 559 to medical cases and 28 on grounds of mental illness. The months of July and August were undoubtedly the busy period so far as road accidents were concerned as there were 27 in July and 30 in August. It will be interesting to see in future years how the pattern is tied to public holidays.

CIVIL DEFENCE — AMBULANCE SECTION

On 31st December, 1962, the total strength of the Civil Defence Ambulance Section was 435. During the year 34 new volunteers were enrolled and 14 were transferred or resigned, showing a net gain of 20.

Re-organisation is being carried out throughout the Civil Defence Corps, and the introduction of Bounty has brought a test system into being. This will in time produce a more uniform standard of volunteer.

During the year the Ambulance Section organised Full First Aid for all other Sections. Others attended from the Police, Fire Service, Women's Voluntary Service and peace-time Ambulance Service. A total of 621 attended throughout the County.

Officer training, re-qualification and advanced training courses at Home Office Schools were attended by staff and volunteers.

The Section took part in an eliminating competition in connection with the Regional Tourney, which was held at Silloth, and took first place. In addition to normal training, military courses have been held at Dalston by this Section and training throughout the year has been given to Army Apprentices and to approved schools for the Duke of Edinburgh Awards.

	Ambulances			Sitting-case Cars			Hospital Car Service			Summary of all Services		
	Total No. of Journeys	Total No. of patients carried	Total milage	Total No. of Journeys	Total No. of patients carried	Total milage	Total No. of Journeys	Total No. of patients carried	Total milage	Total No. of Journeys	Total No. of patients carried	Total milage
1961 ...	11937	21293	251758	17716	56730	445453	587	1466	31526	30240	79489	728737
1962 (A) ...	9917	18181	202444	18472	59548	378674	483	1243	21973	28872	78972	603091
(D) ...	3696	10783	126836	—	—	—	—	—	—	3696	10783	126836
	13613	28964	329280	18472	59548	378674	483	1243	21973	32568	89755	729927
Increase or decrease compared with previous year ...	+1676	+7671	+77522	+756	+2818	—66779	—104	—223	—9553	+2328	+10266	+1190

(D) Directly provided services from 1.6.62.

(A) Agency and Supplementary Services.

SECTION 28

PREVENTION OF ILLNESS, CARE AND AFTER-CARE
TUBERCULOSIS

In each successive year over the past decade it has been possible to follow with satisfaction the downward trend in the numbers of notified cases of pulmonary tuberculosis, and to contemplate the ultimate elimination of tuberculosis as a significant problem in public health. The small pilot Mantoux survey of school entrant children at the end of 1961, which was mentioned briefly in my report last year, was re-assuring in so far as it revealed no disturbing numbers of children reaching school age in the areas concerned showing evidence of having been infected with tuberculosis in pre-school years. Unfortunately the proportion of children approached who were finally Mantoux tested was not sufficient to give the results statistical significance.

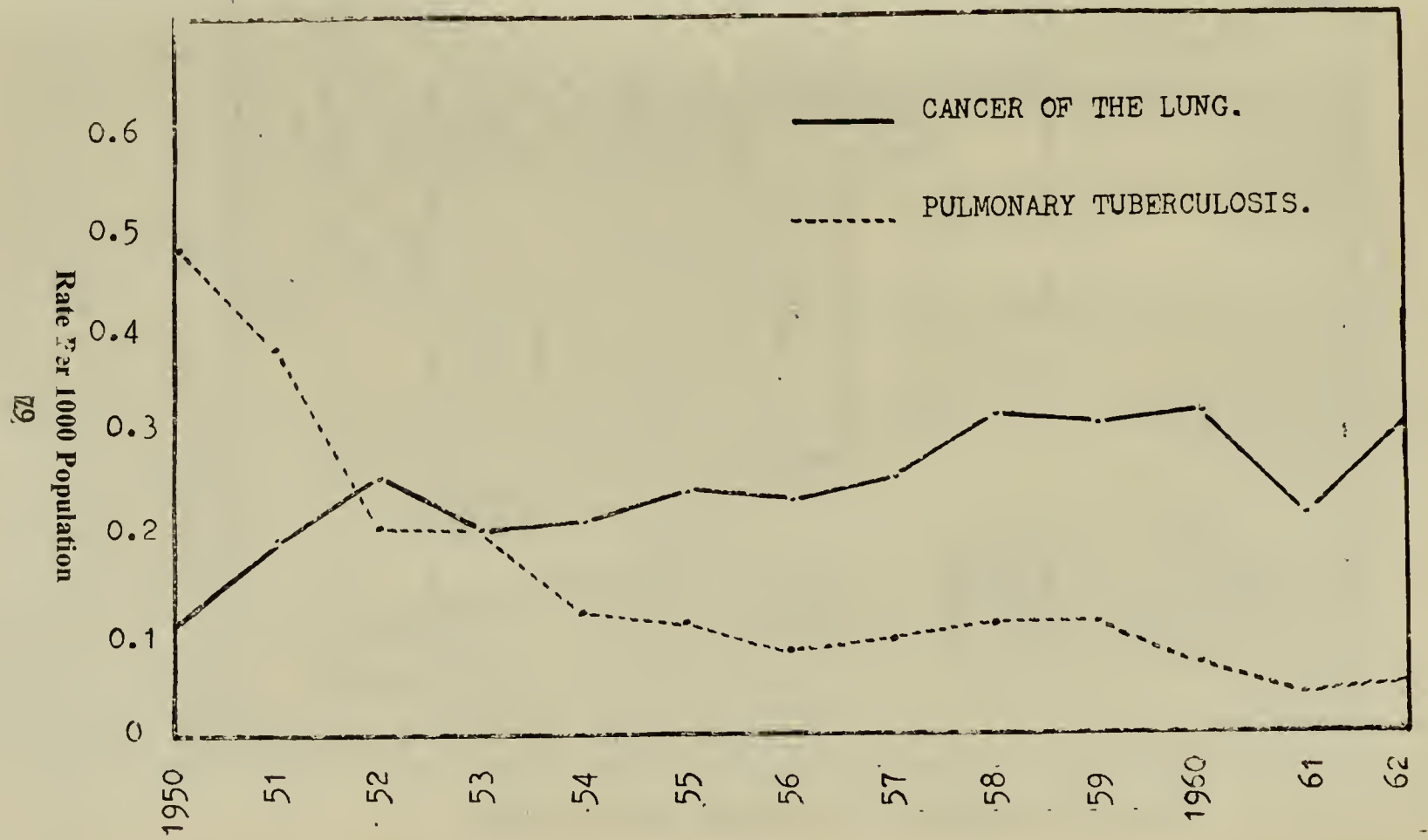
There were 88 cases of tuberculosis notified in Cumberland during 1962. The figure for 1961 was 90, and for 1960 123. On the other hand, the number of deaths registered in which tuberculosis was mentioned was reduced in 1962 to 22, compared with 42 in the previous year. In these cases tuberculosis was, in most cases, only one of the conditions mentioned, in the cause of death. Of the 22 cases 18 were men—15 being over 50 years of age, and 7 over 70. Three of the four female deaths were over 70 years of age. The following table again shows the notifications of pulmonary tuberculosis by sex and age.

	0-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-	+	T
Males	—	4	1	—	4	13	12	14	4	1		
Females	—	3	3	2	2	11	4	3	5	2		

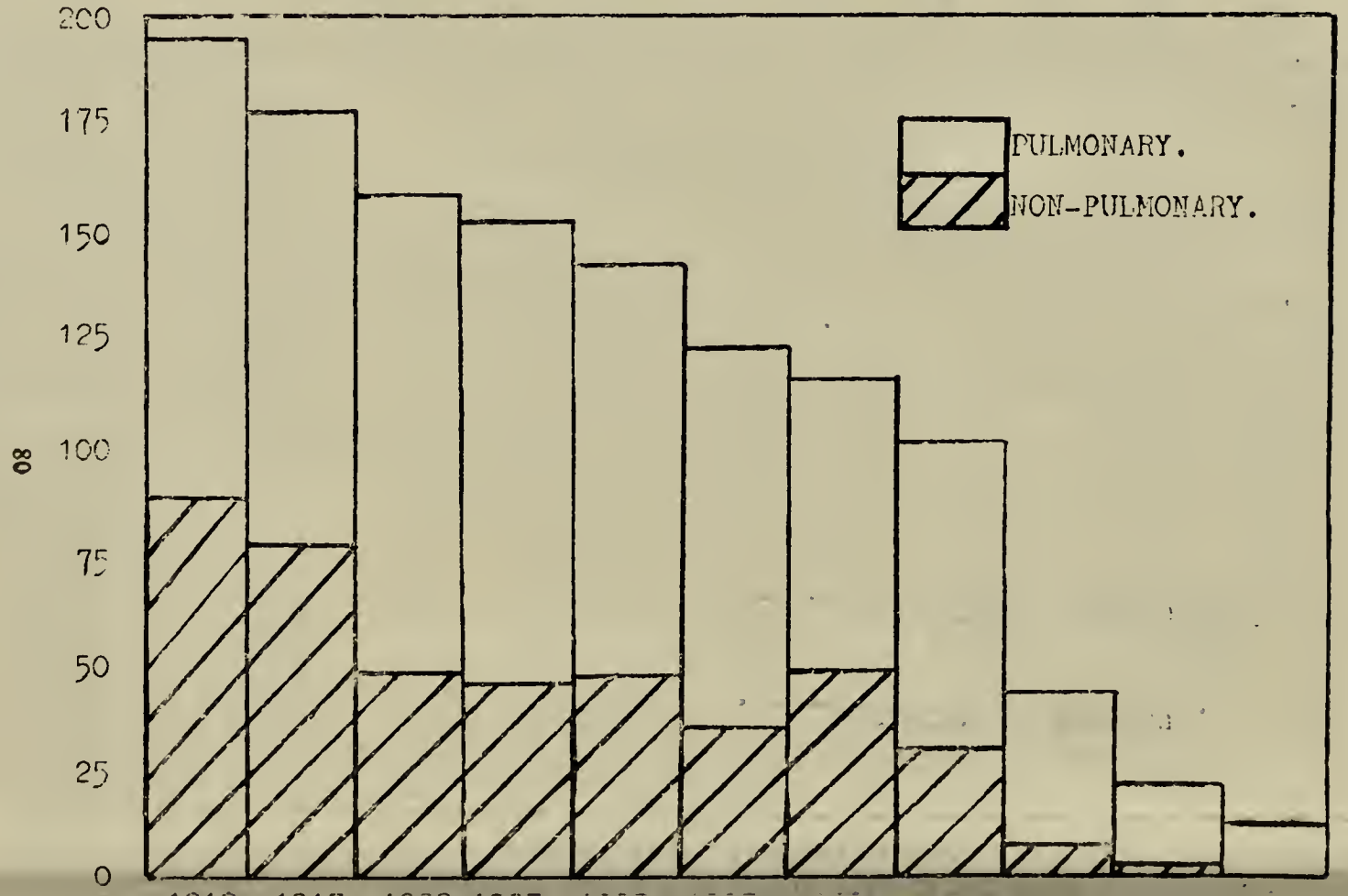
The preponderance of males is in a younger age range than might be expected from general previous experience.

Dr. Morton and Dr. Hambridge, Consultant Chest Physicians in East and West Cumberland respectively, have again kindly provided me with reports on the chest services on each side of the county, which are printed as Appendices 1 and 2 of this report. These reports are somewhat shorter than in previous years, and indicate the need for a sustained effort against tuberculosis to ensure its complete conquest, and prevent any further resurgence of the disease.

DEATHS FROM CANCER OF THE LUNG AND
PULMONARY TUBERCULOSIS



TUBERCULOSIS DEATHS (ALL FORMS) 1912—1962



After Care of Other Illness

The following table indicates the major items of loan equipment which have been issued during the previous five years. No charge is made to the patient for this service and the continuing need for any particular item of equipment is reviewed annually.

Equipment	Items Issued During 1958	1959	1960	1961	1962
Commodes ...	38	15	34	49	76
Crutches ...	5	8	11	9	17
Hospital Beds ...	6	10	12	6	11
Invalid Chairs—					
Adult Type ...	67	69	71	83	105
Junior Type ...	6	10	11	11	10
Mattresses—					
Inflatable ...	—	—	3	7	3
Rubber ...	25	28	28	16	31
Tripod Walking Aids ...	15	35	53	46	91

It will be seen from this year's figures that the demand for most major items of equipment is increasing. Requests are also received for other various items, and wherever the need is established every endeavour is made to provide items which enable the patient to be made as comfortable as possible. The district nurses have stocks of bed pans, bed cradles, urinals, rubber rings and plastic sheeting amongst other items, available for immediate issue, whilst the main items are distributed from Carlisle, Whitehaven and Workington.

Convalescence

The following table indicates the number of persons for whom convalescence has been arranged by the County Council over the last five years.

Convalescent Home	1958	1959	1960	1961	1962
Silloth ...	19	31	38	35	55
Boarbank, Grange-over-Sands ...	6	4	—	1	1
Others ...	3	1	2	—	5
Totals ...	28	36	40	36	61

There was a considerable increase in the number of admissions during the year, due mainly to the fact that the domiciliary nursing staff, who work so closely with the general practitioners responsible for the largest number of recommendations for convalescent treatment, were informed that the Home at Silloth was open during the winter months and that vacancies were available. Even during the severe weather patients continued to go to the Home.

The health visitors are notified when a patient is to be admitted so that they can visit and, particularly in the case of old people, settle any worries they may have about going and encourage them to make the journey, pointing out the benefit they would derive from the rest and change of air. In one case when the health visitor called the old lady informed her she could not possibly leave her home in February because of the risk of burst pipes, and also that she did not know how to get to Silloth. The health visitor arranged for a neighbour to look in every day to see that everything was in order, advised her about transport and helped with her preparations for leaving home.

Some people for various reasons cannot go to Silloth and arrangements are made for them to be admitted to other Homes. The Metcalf Smith Convalescent Home, Harrogate, will accept diabetics and those requiring special diets and last year we had occasion to send two patients there.

I am a member of the Silloth Convalescent Home Committee with provision for my Deputy to attend in my absence. This has proved a very helpful link with such a valuable institution which is still run on an entirely voluntary basis.

All cases are assessed according to income and contribute towards their stay in the Home in accordance with the County Council scale of charges.

Orthopaedic Treatment

Miss J. Fraser, Orthopaedic Physiotherapist, made the following report on orthopaedic work:—

" It is very apparent now that the general physical condition of the under fives is much better than it used to be.

Severe cases of knock-knees and bow-legs are rare, and minor deformities of this type respond to treatment—in most cases before the children reach school age.

Footwear for small children is, on the whole, of a good type, and easily obtainable; except when boots are required. In the case of older children and teenagers, however, it is most difficult to find suitable school shoes in the shops and, even when obtainable, to persuade these children to wear them.

Following their discharge from hospital, the After Care of adult patients is undertaken in the clinics or in the home. At present these patients are mainly hemiplegics, arthritics, or suffering from chest conditions.

Rehabilitation at home after a stroke is particularly important, and we would greatly appreciate further liaison with the general practitioner, whose co-operation would enable us to carry out supervision after hospital treatment has been completed.

The chief aim in the treatment of these patients is to encourage them to use their affected limbs in the essential tasks of ordinary day-to-day living, and not merely to perform exercises as such. In this way they gradually regain some of their former feeling of usefulness and independence which is such an important factor in helping them to come to terms with their disability.

The opinion is generally held that treatment should be discontinued as soon as is expedient. Where the housewife finds herself able to carry out simple household duties, and resume her place in the family circle, an occasional visit from the physiotherapist is all that is required. However, in other cases, it has been found that even where there has appeared to be no recovery whatsoever in a paralysed arm, and physiotherapy was discontinued, that when it was re-instituted, even after a lapse of a year, and the patient encouraged to make greater effort, some recovery of muscle power was evident.

Occupational therapy is of inestimable value in such cases, particularly for men, who have no household duties to occupy their time. The psychological effect of further physical recovery and the added interest of creative effort must not be under-estimated."

Prevention of Blindness, and Care and After-Care of Blind or Partially Sighted Persons

Follow-up of Registered Blind and Partially Sighted Persons — 1958-1962

A.

	Cause of Disability			
	Cataract	**Glaucoma**	**Retrolental Fibroplasia**	**Others**
December, 1958—				
(i) Treatment (Medical, surgical or optical) ...	21	5	—	23
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	7	4	—	6
December, 1959—				
(i) Treatment (Medical, surgical or optical) ...	24	8	—	21
(ii) Number of cases at (i) above which on follow-up action have received treatment ...	11	7	—	11
December, 1960—				
(i) Treatment (Medical, surgical or optical) ...	16	6	—	23
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	7	6	—	12
December, 1961—				
(i) Treatment (Medical, surgical or optical) ...	14	7	—	23
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	5	7	—	13

December, 1962—					
(i) Treatment (Medical, surgical or optical)	...	21	2	2	14
(ii) Numbers of cases at (i) above which on follow-up action have received treatment	...	9	2	2	9

B. Ophthalmia Neonatorum : There were no cases notified during the year.

During the course of the year the five home teachers of the blind who had been employed throughout the County on an agency basis were taken into direct employment of the authority. The aim then was to ensure that their work was integrated with those of other field workers such as district nurses, health visitors, and to this end arrangements were made for relevant extracts from B.D.8 received from the ophthalmologist to be sent to the field officers concerned. In particular where treatment of a medical, surgical or optical nature is recommended this is automatically followed up by the district nurse.

Health Education

It is generally agreed that health education is implied in every medical and nursing activity, irrespective of the setting in which the nurse functions. It aims at promoting the best possible well-being of the individual and a happy adjustment to society, covering the widest possible field. It can be as effective given as an impromptu talk to a mother in an isolated cottage on any aspect of the welfare of her children, as it can be to a captive audience in a clinic.

Health education is not merely propaganda or instruction. It aims at enabling the learner to make his own choices and decision about health matters by putting before him, and making him aware of, the vast field which is covered, in ways simple or profound according to his ability to assimilate knowledge.

During the year opportunities for health education in the county have been extended. The nursing staff upon whom so much health education devolves have attended lectures and courses, both in-service and study days arranged by the branches of the Royal College of Nursing and the Royal College of Midwives, and a number have attended postgraduate courses elsewhere bringing back the new procedures they have learned and imparting the knowledge gained to the rest of their colleagues. Health education of the nurse in training has continued by the administrative staff giving the lectures on social aspects of disease to the students at the Cumberland Infirmary and West Cumberland Hospital, and also to the pupil enrolled nurses at Workington Infirmary. Talks on varying subjects, e.g., The Care of the Elderly, Diet for the Over 60's, Aids for the Handicapped, have been given to many Old People's Clubs and Women's Institute meetings, both by the administrative staff and the nurses in the field. The number of projectors has increased to nine, but more are required and each clinic needs its own equipment. Health education demands equipment which must be kept up-to-date and film strips, flannelgraphs, etc., need constant supervision and renewal—what was new last year is out of date this, so quickly do things change.

Ministry Circular 7/62 "Development of Local Authority Health and Welfare Services; Co-operation with Voluntary Organisations" authorised the use of voluntary help in a much wider field, and we felt that the voluntary worker could take a useful part in assisting at clinics in order to release the health visiting staff for more specialised work for which they are trained. The Women's Voluntary Services were approached and agreed to help.

and committees of voluntary workers are now functioning at 11 clinics in both East and West Cumberland. They are helping with registration, weighing the babies, amusing the toddlers and providing a cup of tea. This gives the health visitor more time to advise, to have discussion groups and to give talks. The voluntary workers first had a meeting with the nursing officer and health visitor to discuss the needs of each clinic and were informed of the confidential nature of the work and how they could best help. The result has been very satisfactory and the workers themselves find they are doing a definitely worthwhile job and are keen and efficient.

Health education in schools and among young people is expanding and nurses are giving talks in secondary modern schools on such subjects as Personal Hygiene, the Care of the Hair, Good Grooming, How to run a Home, and allied subjects.

Health visitors have taken classes for the Duke of Edinburgh's Award Scheme in Penrith, Whitehaven and Workington, and Mothercraft and Relaxation classes in co-operation with the midwives.

Classes for Home Nursing with Junior and Senior Groups of St. John's Ambulance and the British Red Cross Society have taken place in Braithwaite, Egremont, Cleator Moor, Keswick and Millom.

Old People's Welfare Clubs

Health education can be continued throughout the span of life and many elderly persons living alone and rather isolated have been brought back into the community by joining one of the clubs in the locality of their homes, and instead of stagnating take on new interests.

One of the district nurse/midwife/health visitor's writes how she formed an Old People's Club in her area — " Our greatest problem was accommodation. The first offer, an old chapel, was ideal but certain restrictions prevented us accepting. We then negotiated for the use of the Council room which was agreed. The opening of the Evergreen Club was announced at the Christmas Turkey Supper, a committee was formed from the old people and they still run the club themselves. The objects of the club were, to meet at regular intervals, to provide interests both for mental and occupational recreation, health education, and to be self-supporting. The Committee meet each month to arrange

with my help the programme for the month's activities which include speakers on health subjects, film shows, and in the summer outings to places of interest. The enthusiasm of members and the happy meetings speak for themselves for the success of the club."

The health visitors and nurses are also members of old people's welfare committees and give invaluable help, taking a part in giving talks on such matters as Diet, Safety in the Home, Aids to the Elderly and other subjects. One old man was heard to say after attending a talk on Food for the Over 60's "I now see why milk is important and I shall take a pint a day."

Mothers' Clubs

The formation of Mothers' Clubs has been encouraged and during the year one has been established at Brampton. To begin with it was held in the afternoon but it was found that the mothers had to bring their small children, and although they were catered for, the attention of the mothers was not whole-hearted. A suggestion was made that it should be held in the evening. Since then the membership has risen to 36 and the mothers feel they can relax better away from the family. There is an active Secretary and Treasurer. A small fee is charged and tea and biscuits are provided. The business is dealt with by the mothers who make arrangements for speakers. The subjects have been Accidents in the Home, Habit Training, Continental Cooking, Care of the Feet and Teeth, and a talk by a speech therapist. The present programme includes other health educational subjects and demonstrations. The mothers are very enthusiastic and enjoy managing the club themselves.

At Thornhill a group of mothers met at home and made a very good tape recording of a discussion they had on the Prevention of Accidents in the Home. They hope to form a club here in the future.

Smoking and Health

Special mention is requested by the Ministry of Health this year of the measures taken to bring before the public the dangers of smoking. Considerable impetus was, of course, given to this subject by the publication early in the year of the Report on Smoking and Health by the Royal College of Physicians. This

added a new weight of authority to the warnings on this subject previously based mainly on a series of research projects. Emphasis was rightly laid on efforts to prevent young people from starting to smoke, and on the possibilities of helping adults who wished to stop smoking, but had difficulty in knowing how to go about this. In Cumberland the appropriate posters were, of course, supplied to clinics and other departmental and Local Government establishments where they would be in the view of significant numbers of people, although the value of this as an isolated measure has long been under suspicion in health education.

More important are the efforts which school medical officers and school nurses have made to reach as many and as wide school audiences as possible. All have been given, or have requested and obtained, opportunities of speaking to groups of school children, and some success has been achieved in stimulating discussion of the subject, mainly with younger secondary school children—probably the critical group to reach. Then school activities have in some instances included parent teacher groups, and one school medical officer has made a circuit of secondary schools in his area using the film, " Spotlight on Smoking ".

A reservation was made during the year of the services of one of the Central Council for Health Education Mobile Units to visit the most populous area of the County later in 1963 with a view to making a concentrated impact there, and also maintaining momentum in the local interest in the subject.

In two areas of the County — in Millom and in Penrith, experimental Smokers' Clinics were commenced during 1962. In Millom, a town of 7,000 population, total attendances were 72 at the 6 sessions which were held. Unfortunately staff changes made it difficult to pursue this venture in this area. In Penrith the total attendances were 26, and here again there was considerable difficulty in maintaining interest.

The clinics took the form chiefly of group-therapy discussions, in which it was possible in some instances to harness the assistance of individuals who had themselves been smokers but had been able to discontinue the habit. In suitable cases drug therapy was also used to surpress the desire for smoking. In each case the agreement of the General Practitioners in the area was secured, and some of those attending had come as a result of the suggestion of their own Doctor. The Chest Physician in the area was also very interested in the project, and the advertisements of the clinic sessions in the local press were widely noted as well as attracting a certain amount of separate useful press comment.

CHIROPODY SERVICE

At the beginning of the year the authority's free chiropody service for the elderly, expectant mothers and the physically handicapped had been in operation for only fourteen months, but there were 2,153 people receiving treatment. The number grew steadily by about 25 a week to 3,305 at the end of the year, an increase of rather more than 50 per cent.

To meet this steep increase more time has had to be taken up with chiropodists working in private practice and whereas 13 of them were giving the equivalent of 39 sessions a week to County work in December, 1961, it had reached 61 sessions by the end of December, 1962. One full time chiropodist worked for the authority throughout the year and repeated efforts were made to recruit another, but without success. Until the salary scale is increased appreciably the chances of recruiting full-time staff seem to be remote. Fortunately, it was possible to make arrangements with another two chiropodists for them to undertake sessional work at a clinic, bringing the total of those engaged on sessional work to 15. Arrangements were concluded with another to begin early in 1963.

During the year the scheme was extended to Silloth, where a clinic is held each week in rented premises. Each of the Old People's Homes in the county is visited regularly by a chiropodist.

Under the county scheme the chiropodists are authorised to treat each patient referred to them by a doctor or member of the authority's nursing staff six times during the course of a year, although a few are, on medical grounds, treated more frequently. The total treatments given during the year amounted to 14,939, of which 74 per cent. (11,056 were women). A further breakdown of these figures reveals that 2,819 (19 per cent.) were domiciliary treatments and 12,120 (81 per cent.) were given in clinics or surgeries. Of the non-domiciliary treatments, 98 per cent. were for the elderly—men of 65 years of age and over the women of 60 and over—2 per cent. were for the physically handicapped and a negligible proportion (a total of only 67 treatments throughout the whole year) were for the remaining priority group, expectant mothers.

Domiciliary visits continue to pose a problem because, apart from their cost, they take up a great deal of valuable time. While they accounted for 19 per cent. of the treatments throughout the county, a slight improvement on the 20 per cent. recorded in 1961, individual districts varied greatly. At one end of the scale, in

the Longtown area less than 2 per cent. of the patients need domiciliary treatment, while at the other extreme the figure in the Whitehaven area is 31 per cent. The disproportionate amount of time spent on domiciliary work can be illustrated by referring to the statistics submitted by the county's full time chiropodist, Mr. G. H. Thomas, M.Ch.S. Although 32 per cent. of the treatments he gave were domiciliary they took up 65 per cent. of his time.

Apart from the disproportionate amount of time they take, these visits also cause the chiropodists concern because of the difficult operating conditions presented, and it must be said that occasionally it is not easy to reconcile the patient's mobility with the special referral for domiciliary treatment. The most outstanding example of this was the patient who took a morning off work to stay at home to await the chiropodist's visit. The irony of this situation was increased when it was learned that the patient actually worked within a few yards of a clinic where treatment could have been given. Where there is reasonable doubt in a chiropodist's mind about the need for domiciliary treatment the co-operation of the family doctor is sought to review the position. However, in a few cases we have to agree to differ and go on providing home visits.

Another point which emerges from Mr. Thomas's records is that almost 10 per cent. of the appointments he made for patients to attend treatment centres were not kept, compared with 8 per cent. last year. The main reasons for absenteeism seem to be illness, forgetfulness, holidays and inclement weather. Generally speaking, the patients are quick to let Mr. Thomas know and apologise afterwards, but by then it is too late to utilise the time. While some failure to keep appointments must be accepted among the elderly, this increase is disquieting, especially when one considers the ever growing list of patients awaiting treatment.

Although the service has grown quite rapidly it is pleasing to be able to report that it has done so with few difficulties and those which have arisen have been resolved quickly with good will and co-operation all round. For this my thanks are due especially to the chiropodists, the Old People's Welfare Committees who act as the authority's agents in certain areas and without whom, in present circumstances, these areas would have no service or one much restricted, and those voluntary bodies who provide transport to get patients to treatment centres from outlying places.

It is interesting to look back at the results of the survey into the need for chiropody which was reported on fully last year. With the agreement of a number of general practitioners who had been chosen at random, a survey was carried out among a random sample of their elderly patients. One of the factors which emerged from the survey was that 11 per cent. of the people of pensionable age in the county were in need of immediate treatment. At the end of 1962 just over 10 per cent. of the group were in fact being treated under the County scheme.

The survey showed also that of those in immediate need 73 per cent. were women and 27 per cent. men. As I mentioned earlier, 74 per cent. of the elderly treated during 1962 were women.

It is a coincidence that 11 per cent. of the elderly, would seem to be not far short of the number of patients who can be treated, unless there is an increase in the amount of chiropodists' time available to the Council; and this grave shortage of chiropodists is the factor which is causing most concern at the present time. The increase in the number of elderly each year must increase the number of patients referred for chiropody and unless the staffing situation improves fairly soon the expansion of the survey will be seriously restricted, it will not be possible to keep pace with referrals and waiting lists will unavoidably grow longer.

VENEREAL DISEASE

The best results for obtaining the control of venereal disease are almost certainly achieved by an enlightened system of Health Education and by providing centres for the expert diagnosis and early treatment.

Arising out of the recommendations of the Royal Commission, the Public Health (Venereal Diseases) Regulations, 1916, were issued requiring councils of counties and county boroughs to make arrangements for the examination and treatment of cases suspected to be suffering from venereal disease; all information obtained was to be treated confidentially and the clinics were held at hours most convenient to the patients. The venereal diseases services has now been taken over as a specialist service under the Regional Hospital Boards. The local health authority is responsible for the preventive side of the work, including the tracing and the follow-up of defaulters.

These Regulations produced in this country the finest V.D. Service in the world, and bred a body of medical experts who regarded themselves not merely as clinicians, but as part of the Public Health system. They were closely integrated with the administration of the local Medical Officers of Health and were as active in the control of the venereal diseases as in their diagnosis and treatment.

This close liaison between Medical Officers of Health and Venerologists has not, unfortunately, been as encompassing as hoped, mainly I think because of the assumption that the introduction of new antibiotics alone would be sufficient to control V.D. This uninformed opinion resulted in the closing down of clinics and a reduction in the number of venerologists. Obviously the optimistic forecast was premature and I think it is important to remember that venereal diseases are social diseases and require more than a medical approach for their prevention and eradication. Control depends ultimately on successful contact tracing and possibly the best person qualified for this delicate task is the Health Visitor.

Venereal Diseases

I am indebted to Dr. H. J. Bell, Consultant Venereologist for his permission to publish the following extracts from his Annual Report to the Special Area Committee of the Newcastle Regional Hospital Board.

For some years the following Table has had a place in this Report :—

Table 1

Year	Early V.D. Infections		Total Attendances	
	Carlisle	Whitehaven	Carlisle	Whitehaven
1952	51	13	2081	870
1953	43	17	1924	976
1954	48	18	1461	619
1955	48	26	1202	641
1956	60	23	909	450
1957	45	17	741	362
1958	45	22	806	301
1959	69	20	893	398
1960	74	20	920	472
1961	67	20	755	454
1962	70	52	640	473

The expression 'Early V.D. Infections' includes patients attending for the first time with gonorrhoea, non-specific urethritis, and syphilis (of less than one year's duration). Over the years reported, the figures for Cumberland Infirmary remain remarkably static, but the figure of 52 last year at Whitehaven represents something new. During the summer months there was a sudden outbreak of gonorrhoea in Workington propagated by a number of 'good-time' girls, who haunted the leading public-houses in the town. They were unusually promiscuous. Under the guidance of Dr. Leiper, the County Medical Officer of Health, an emergency organisation for tracing of contacts in the area was set up, and most of these women were brought to treatment. This campaign, carried out by the Lady Almoner of Workington Infirmary, assisted by

Health Visitors, was undertaken with such gusto that it became the talk of the town — at least, among the teenagers. As a result, many young men and women presented themselves at the Clinic in case they might have been infected.

Only one example of early syphilis was dealt with in Cumberland in 1962, but the source of infection was over-seas. In neither of the Clinics were there any new cases of congenital syphilis.

The totals of all new cases, whether venereal or non-venereal, are included together in the following table :—

Table 2

Year	New Cases seen for the FIRST TME	
	CARLISLE	WHITEHAVEN
1952	274	95
1953	250	92
1954	219	87
1955	168	74
1956	136	78
1957	173	61
1958	191	45
1959	213	63
1960	248	72
1961	240	101
1962	219	126

The Carlisle Clinic continues to show small and unpredictable variations in numbers, but the recent increases at Whitehaven are probably significant. There is a number of younger men lodging in the area who are employed by contracting firms in West Cumberland, and their homes are outside the County. I find that these men, both married and unmarried, account for the majority of male patients consulting me. The influence of foreign workers, noted in the larger Clinics elsewhere in England, is not a factor in this area.

Over the County as a whole, the most interesting development of 1962, was a halt in the rising figure for non-gonococcal urethritis, and an actual diminution in gonorrhoeal patients. This is the first evidence of improvement over the last eight to nine years. Table 3 below shows the situation.

Table 3

Fresh Cases of Gonorrhoea

Year	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
ENGLAND AND WALES ...	19095	19263	17536	17845	20388	24381	27915	31328	33640	37026	35271
SCOTLAND ...	2863	3251	2798	2545	2708	2831	3324	3382	2937	2959	3130
CARLISLE ...	26	16	22	21	38	25	28	34	42	36	33

The most distressing and vexatious problem facing my colleagues at this time is the recruitment to the speciality. It is true that young doctors, these days, find it extremely difficult to acquire the experience of clinical cases that was the luck of their predecessors. For many of these older men were presented with a vast clinical material during the war years, and there were others who were active in the specialty even before the era of chemotherapeutics (sulphonamides ,etc.) and antibiotics (penicillin, etc.) — a time when complications were the order of the day, and when the entire vista of V.D. pathology was to be reckoned with, and was not smothered over as it is today by an umbrella of antibiotic concealment.

Prior to 1948, the V.D. clinic was the charge of a sub-committee of the local Public Health Committee. The Chairman was the Medical Officer of Health and the members were laymen. They paid a rent to the local hospital for clinic premises and, with government help, they finance the cost of running the service. The members of the committee were intensely interested in the work of the venereologist and acted as his sponsor, champion, and — at times — as his critic. It would be an improvement to see the Medical Officer of Health brought back into the administrative set up.

What, then, are the special functions of the individual special treatment department ? The standard misconception is that V.D clinics are exculsively concerned with the diagnosis and treatment of gonorrhoea and syphilis. In an average clinic more than 75 per cent. of the patients are suffering from neither of these conditions. The unique responsibility of the V.D. team is not the problem of diagnosis and treatment, but the control and prevention of disease. This is the work of 'contact-tracing' and 'case-finding.' Were there no V.D. clinics there would be no V.D. control. Although the Medical Officer of Health and other ancilliary organisations may give all kinds of help in this effort, its initiation and direction derive from the clinic itself. Every example of syphilis — especially late syphilis — entails endless enquiries and hours of work before it can be certain that all contacts have been accounted for and examined. This is a silent service in that it is not itemised in hospital statistics. The rewards as revealed in the salvage of human lives and human happiness in this branch of preventitive medicine can,

however, be sensational. The day-to-day problems of contact-tracing as it happens are mostly concerned with gonorrhoea patients. The distressing paradox here is that women patients infected, are seldom aware of their condition. They have to be found and brought to treatment before complications develope. They never report of their own accord, but only through the agency of male consorts who have been treated at the clinic. What happens to women left untreated can only be a matter of conjecture — at the worst peritonitis or sterility, at the best the development of a carrier state which renders them a menace to others for many months.

National rates show that for every four men who apply for treatment of gonorrhoea, only one woman presents herself; (in our local clinics, the proportion is more satisfactory, because contact-tracing is less difficult). Nevertheless, over the country as a whole, there must be about five and a half thousand women who never come under treatment at all. For this reason, the staff of any V.D. clinics are prepared to pursue their search for contacts to the utmost, to seek out the unsuspecting female. Whereas in most European countries like France, Finland, Poland and Denmark, the local Authority has legal sanction to enforce the attendance of contacts and defaulters, there is no such warranty in Great Britain.

Nevertheless, the effort goes on unremittingly with contact slips, telephone calls, letters and the rest — with readily-available help from Medical Officers of Health, Health Visitors, Lady Almoners and others.

What has been written above is a mere thumb-nail sketch of the work of a trained venereologist. The nature of his service is such that personal anomymity and even obscurity are assets to him in the performance of this task.

Finally, I append a Table showing the place of origin of the new cases who attended the two clinics in Cumberland during 1962 :—

Table 4

Town or Area	To Carlisle Clinic	To Whitehaven Clinic	Total
FROM—			
Carlisle and suburbs ...	94	—	94
Aspatria ...	8	—	8
Bassenthwaite ...	—	1	1
Brampton ...	4	—	4
Cleator Moor ...	—	6	6
Cockermouth ...	4	10	14
Distington ...	—	3	3
Dumfriesshire ...	11	—	11
Egremont ...	1	5	6
Frizington ...	—	3	3
Gosforth ...	1	1	2
Keswick ...	10	—	10
Lamplugh ...	—	1	1
Longtown ...	1	—	1
Maryport ...	6	8	14
Penrith ...	12	—	12
Silloth ...	1	—	1
Spadeadam ...	1	—	1
Whitehaven ...	4	27	31
Wigton ...	1	—	1
Workington ...	11	51	62
Others ...	49	10	59
	219	126	345

MENTAL HEALTH SERVICE

In my last annual report (at the end of the first full year's work under the new Act) I was able to report that, although the new area of care and support for the mentally sick in the community was ill defined in size and dependent on changing conditions in theraputic services, I was satisfied that the local health authority's domiciliary care services could make a notable preventive contribution. Now that another year has gone by during which the community care services have shown extensive development in close association with the hospital and general practitioner services, I am convinced that in the prevention of illness the need to provide community care services for the mentally ill is as important at the present time as were the efforts of the public health services of a few decades ago in the control of the major infectious diseases.

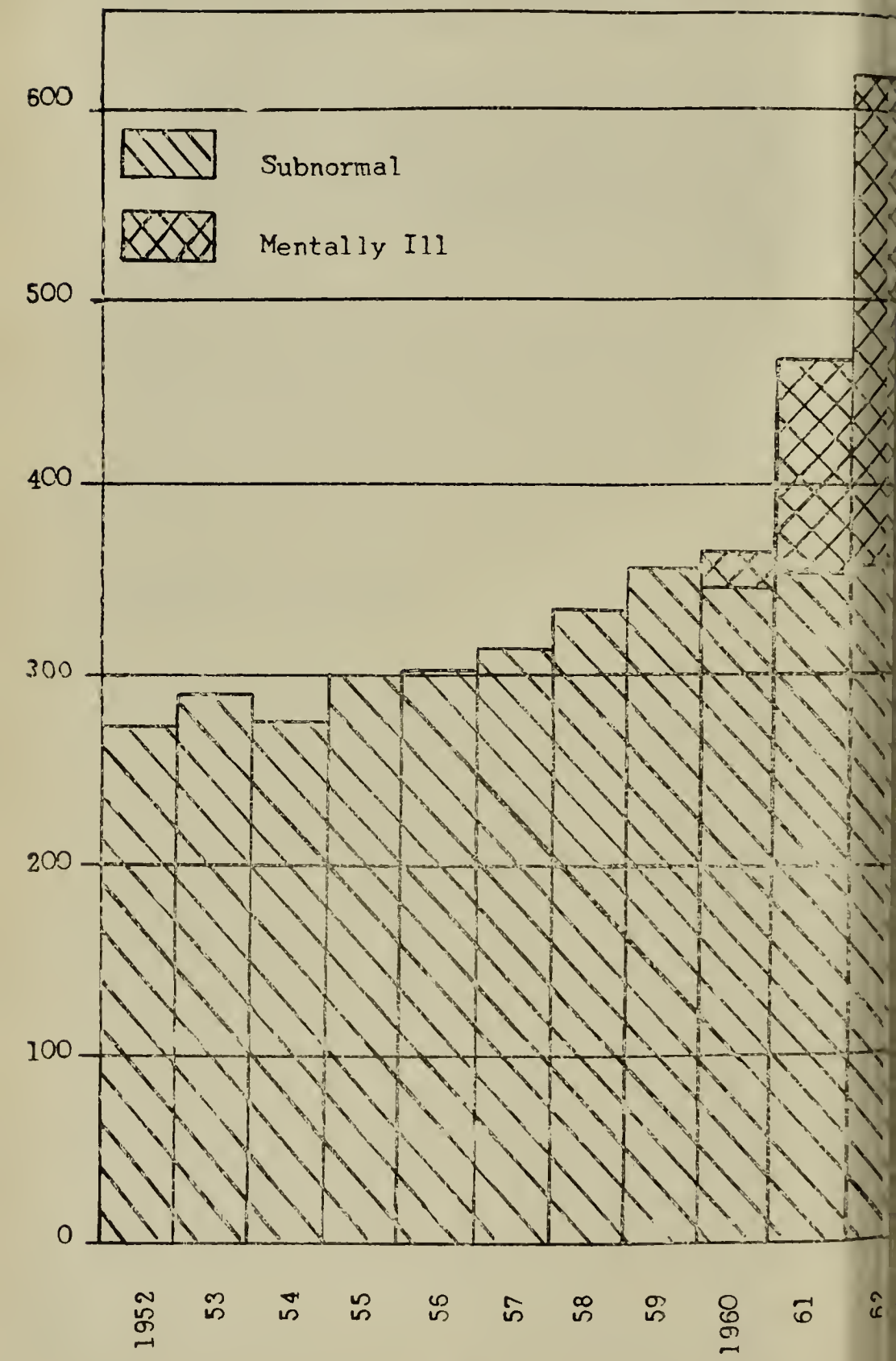
Domiciliary Care Services

It is our policy to man the local health authority's mental health service by fully trained whole-time officers, who will undertake all the aspects of domiciliary social work in the mental health field. The foundation of this policy was laid down in 1958 when the Council adopted inservice training schemes for psychiatric social workers and mental welfare officers. Whilst such schemes are inevitably slow in providing trained staff in the field, dividends ultimately accrue. At the end of March, 1962, I was able to dispense with the services of part-time officers (former "duly authorised officers") in West Cumberland, the needs of the whole of the administrative area being met by full-time all purpose mental welfare officers. The present establishment (in addition to the mental health officer whose duties become increasingly administrative in nature) consists of one senior mental welfare officer and six mental welfare officers. At the end of the year all these posts were filled, the senior mental welfare officer being also qualified as a psychiatric social worker. In addition I was fortunate enough to secure the services of a mental welfare officer in a temporary capacity to cover the period during which a permanent member of staff was absent for training as a psychiatric social worker.

The graph which follows shows the total caseload of the mental welfare officers at the end of 1962 and illustrates the effect on the local health authority's domiciliary care services of the duty to provide services for the mentally ill in the community. The ultimate need for support of this type cannot yet be forecast with any accuracy, but it seems to me quite clear that much remains yet to be done in continuing to co-ordinate our efforts with our colleagues in the hospital service and in general practice to provide from all branches of the local health authority services whatever support or care is needed for the mentally disordered living in the community.

Mental Welfare Officers

Domiciliary Case Load at 31.12.1962



The table which follows analyses the sources of referral of cases coming to the authority's notice for the first time during the year under review, the comparative figures for 1961 being given in brackets.

Source of Referral	Mentally ill	Psycho-path	Subnormal and severely subnormal	Total
General Practitioners ...	59 (46)	— (—)	3 (5)	62 (51)
Hospitals—on discharge from in-patient treatment ...	124 (82)	3 (1)	8 (3)	135 (86)
Hospitals—after or during out-patient or day treatment ...	26 (28)	2 (—)	2 (5)	30 (33)
Local education authorities ...	— (—)	— (—)	39 (10)	39 (10)
Police and Courts ...	2 (11)	— (—)	3 (3)	5 (14)
Other sources ...	18 (26)	1 (—)	16 (9)	35 (35)
	229 (193)	6 (1)	71 (35)	306 (229)

It will be noted that more than half of the new referrals (165 out of a total of 306) came from the consultant psychiatrists in psychiatric units in hospital or their associated out-patient clinics, and about one in every five directly from general practitioners. What is perhaps more significant is the fact that three out of every four cases referred required help from local health authority services because of mental illness — a group of the mentally disordered for whom no service was available until the Mental Health Act came into operation. It has always been my aim and will continue to be my intention to provide the best possible service for those who need it, and these ideals cannot be achieved without the full support and collaboration not only of other branches of the service but also from other statutory agencies and the voluntary bodies who have such valuable contributions to offer.

Community care cries out for co-ordinated team work, and I feel that it is the duty of the local health authority (since it now has a statutory mandate to extend its pre-care and after-care services to all types of the mentally disordered in the community) to co-ordinate effort to the one goal—the well-being of the patient and the stimulation of those conditions which enable the patient to remain within the community wherever possible. As a corollary to this I feel that it is also our duty to do what we can to make the nebulous "community" really care about playing its part in keeping the patient at home.

The views of two consultant psychiatrists (Dr. W. G. A. Begg for East Cumberland, the Medical Superintendent of Garlands Hospital, and Dr. A. C. Gibson for West Cumberland), on the development of our community care services, for the mentally disordered to date have been sought, and are expressed as follows:

Dr. Begg writes:—

"I personally am very satisfied with the work of the Mental Welfare Officers and I have nothing but praise for their endeavours. When I personally have asked them to visit patients they have invariably done so and their reports have been exceedingly helpful. I think this is the main contact at present which we have between your Department and mine, and I would like to state again that it is of the uttermost value and help to me. I hope that this particular aspect of the service will go from strength to strength and I envisage that more and more of the routine visiting of patients in the community will be done by them.

I would like to take this opportunity of saying that I am extremely happy about the co-operation between our respective departments. I think that they are complementary to one another and that together they are doing an important job to the limit of their present resources. I would also like to take the opportunity of thanking you for your Department's contribution to the psychiatric service of the area throughout the last year."

Dr. Gibson writes:—

"Advances in treatment of psychiatric illness over the past few years have meant that it is now only necessary for a small proportion of the mentally sick to remain in hospital for long periods, particularly if their illness can be treated early. This does not mean to say that all the patients out of hospital are completely well, and many need the advice and support of somebody trained in this type of work. In the past, hospital out-patient clinics and psychiatric social workers have been able to fill this need, but the number of patients have increased so much that I am glad to say that the Local Authority have undertaken the responsibility in this field.

I am glad to say that in West Cumberland the three mental welfare officers have made a great contribution in after-care work, supporting in all 132 cases. It has been found convenient to link their work with the normal hospital after-care which is undertaken in many instances of nervous illness, and I am glad to say that the two services have integrated perfectly and I have found the work of the local authority officers of great assistance to me. It is easy to see how difficulties can arise between different departments doing the same sort of work, but our experience here has been that if the mental welfare officers are allowed access to the Psychiatric Department and can always speak to a doctor there about any of their problems, difficulties quickly disappear. I think it is true to say that had it not been for the help given from your Department the standard of psychological medicine practised in this area would have been far lower than it otherwise has been."

The table below shows the number of occasions when it has been necessary to apply the provisions of Part IV of the Act relating to compulsory admission procedures since the Mental Health Act came into operation on the 1st November, 1960.

Part IV Admissions

Section	1960 (November and December only)	1961	1962
25 (For observation) ...	16	53	51
26 (For treatment) ...	5	25	28
29 (For observation in emergency) ...	2	31	56

As was expected, in the vast majority of cases where compulsory powers were exercised, the detention was for short-term observation only under Section 25 or 29 (in Cumberland 209 out of 267). In only a small proportion of cases (58 in 26 months) was it necessary to take longer term compulsory powers under Section 26. This annual average of 26 longer term orders for treatment represents almost exactly one-third of the annual average of orders giving similar detentive powers under the former Lunacy and Mental Deficiency Acts.

It is interesting to note that whilst 11.7 per cent. of the county's population is over 65 years of age, the proportion of long-term compulsory admissions to mental hospitals within this age band represented only 12 per cent. of the total admissions under this procedure. This, I believe, is due at least in some measure to the policy of maintaining within the various schemes for the provision of Part III accommodation and partial dependency dwellings as many as possible of those old people who require additional support because of minor mental disabilities.

I have felt that the older residents of the various Part III establishments, often because of the circumstances surrounding the need for their admission, were possibly at greater risk of mental disturbances and confusion particularly during their

"settling in" period. For this reason it is now the practice for each mental welfare officer to make regular contact with the Superintendent, Matron or Warden of each old people's home or group of partial dependency dwellings in his area, so that whatever help may be needed can be arranged without delay. This is real preventive work and minor difficulties sorted out in the early stages do much to enable the resident (in spite of some mental fraility) to remain within the community which Part III accommodation provides.

Training Centres

(a) For Juvenile Subnormals

The full time junior training centres at Whitehaven and Wigton jointly providing 90 places still continue to meet the demand for the daily training of the younger subnormals in the area who are unsuitable for education at school, and in consequence there is no waiting list for such training.

Plans for a replacement of the temporary war-time centre at Whitehaven by a modern purpose designed building are well advanced and I look forward to extending the modern purpose built Wigton Centre in the not too distant future. How then does one reconcile the adequate numerical provision of junior training centre places with advanced proposals for building a new centre at Whitehaven and for enlarging the Wigton Centre? The reason is simply that the whole concept of training has changed beyond recognition since "occupation centres" were first established. No longer is it considered that a child who cannot attend school because of a mental handicap requires only to be amused and kept occupied. The potential for learning through active experience is far beyond what was originally thought. Results come more slowly, but the educational principles applied in the modern primary and junior schools have now been proved in their application to junior training centres for the subnormal. The duty then is to provide the conditions under which modern techniques can be applied and so it is proposed to replace the prefabricated Whitehaven Centre by a purpose designed building and to extend the Wigton Centre to permit better grouping of the children.

Within the limits imposed by lack of proper facilities an experiment was carried out at Whitehaven in introducing a little boy who was grossly handicapped mentally and severely disabled physically. This was tried on a part-time basis primarily to give the mother some relief from the strain of providing the constant care which the child's multiple handicaps demanded. Although paralysed in all limbs, unable to sit up without support and unable to speak, it was obvious that he enjoyed his first experience of associating with other children, which was not possible within the confines of his home. Now he attends daily and looks anxiously for the ambulance which carries him in his wheelchair to the training centre, and there is no doubt whatever that he is profiting from his experiences at the centre, though these are necessarily limited by his handicaps and at the same time his home life and that of his parents is much more fruitful. This type of multiple and severe handicap would until quite recently have been considered only suitable for kindly custodial care in hospital, but the sights both in relation to training and to care within the community are being set lower and lower down the intellectual scale. Local experience confirms that of other authorities, and I shall include within the junior training centres of the future "special care" units for those severely mentally handicapped children often with an associated physical disability, who, until recently, were considered to be untrainable.

In the late summer the experiment was tried of introducing a small group of children from the Whitehaven Centre to swimming instruction at the public bath (in each case with parental consent). The results have been sufficiently encouraging to justify a resumption on slightly more ambitious lines in the spring of 1963.

(b) **For Adult Subnormals**

Plans to have a separate training centre for adult subnormals ready for use towards the end of the year failed to materialise because of intolerably lengthy negotiations over the chosen site. Not until the end of December was the land finally acquired by negotiations—the first move having taken place just over two years' previously. At long last it is fairly safe to say that the building contract will be let by July, 1963, and given reasonable weather and an absence of further delays from other causes, this long awaited unit should be functioning by the 2nd half of 1964. Some slight progress can, however, be recorded in the efforts to extend

training beyond the junior stage. Limited surplus space at the Whitehaven Junior Centre has been used since June, 1961, for the continuation of the training of a group of older boys under a male instructor. This venture was so successful that the need for greater scope in which to foster working conditions and an atmosphere more adult in approach, became increasingly urgent. The area was scoured without success for temporary premises which would tide over the period until the purpose built centre was ready. The opportunity finally came towards the end of the year when a detached part of Meadow View House became vacant following the departure of the Part III residents from the main building and the transfer of geriatric patients into some of the released accommodation. This move of the senior males and females from the junior centre took place on the 18th February, 1963. Many benefits should accrue from this temporary measure —the scope of training can be extended, room will be available not only for those transferred from the junior centre but also for some young adults for whom places were not previously available, the training programme at the junior centre can now be reorganised on more efficient lines and the whole exercise will provide profitable experience in the development of adult training in advance of the specially designed centre.

A male instructor was seconded for the full year's training for the Diploma of the National Association for Mental Health for supervisors of adult training centres in September, 1962, and I look forward to his return equipped with the most up-to-date training which is available in this relatively new field. A second male instructor was appointed towards the end of the year in anticipation of the expected increased intake.

(c) **Parents' Association**

The Whitehaven Parents' Association which came into being in 1960 continues to meet at the Centre at monthly intervals, excluding only the mid-summer months. The Association is run entirely by parents, but both teaching staff and social workers attend their meetings and lend their support. It is interesting to note that membership is not strictly confined to the parents of children who are actually in attendance at the Centre, but includes the parents of some subnormal children who are under hospital care and even the parents of retarded children who are as yet too young for admission to training. The group is kept informed of the Council's long-term proposals for the development of training facilities and in this way their continued support is assured.

Residential Accommodation

(a) For the Subnormal

For upwards of ten years it has been apparent that Cumberland would never be able to fulfil its statutory duty to provide suitable training for all those children in the county who, because of a disability of mind, were unsuitable for education at school unless some form of boarding arrangement was linked to the provision of junior training centres. Having established full-time training centres for juvenile subnormals in the two locations selected to give maximum coverage in relation to population density and convenience of daily collection, the situation was reached where there remained smaller urban areas such as Keswick, Alston, Millom and Brampton, together with numerous isolated villages, particularly in the south and east of the county, which could not reasonably be brought within the collection areas of either centre. For subnormal children in such areas the prospects of training were very poor. Peripatetic home teaching was tried and later abandoned for the reasons which have now become more generally recognised as inherent deficiencies in this form of training. At this stage of impasse, because the demand in any of the county districts outside the catchment areas of the two existing centres was unlikely to justify an additional centre within the foreseeable future, the Council converted a former children's home at Orton Park to use as a hostel for subnormal children as long ago as 1959.

This was a pioneer venture accomplished before the Mental Health Act gave specific powers to provide residential accommodation, and it is with some pride that Cumberland, although its geographical problems are almost without parallel in England and Wales, has been able for nearly four years to offer full-time training to any subnormal child within its million acres. The path of the pioneer is never easy, and a great deal of thought and experiment has gone into this project since its inception. Initial staffing problems were eventually overcome and young, alert staff were recruited to this new work. No form of training was available or even contemplated so that inservice training courses had to be arranged. Every effort has been made to integrate the functions of the training centre which the children attend with that of the hostel where they live and sleep during term times. Although most of the children return to their own homes each week-end and for the training centre holidays, parents have been encouraged

to visit the hostel both individually and collectively so that the link beween hostel and home and between parent and housemother are mutually fruitful. Following Dr. Tizard's experiences in the Brooklands' experiment the small family group pattern of care has been adopted.

At week-ends, but more particularly during school holidays, the hostel is greatly under-occupied, although it is available for short-term care of subnormals other than the normal residents. I have been glad to welcome as fee-paying holiday-makers during the summer vacation parties of subnormal children from Newcastle and the West Riding of Yorkshire who have been accompanied by their own teaching staffs.

It was reasonable to expect that some additional benefit might accrue to those children who, in addition to receiving normal full-time training at a junior centre, had the additional experience of living during term times in a community which was geared to provide conditions most stimulating to their experiences and development. It is, therefore, disappointing to record that social maturation as assessed by one of our educational psychologists using the Vineland Social Maturity Scales is not appreciably greater among those children who have been residing at Orton Park and receiving training at the Wigton Centre when compared with those who attend the same centre from their own homes.

It cannot be denied that a hostel is essential in an area such as this if training is to be available for those children who live in the more remote districts. The fact is that at any time during the past four years up to 22 children have been able to participate in full-time training at a suitable centre, training would have been denied them unless hostel facilities had been available. Since our experiences have suggested that the subnormals' mental progress and maturation is principally the result of daily training at a centre and that hostel residence does not materially enhance the rate of progress, I propose to put my findings to the appropriate committee. It will then have to be considered if the present expense of maintaining a hostel on a seven-day week basis for 51 weeks each year is justified when the same ends could be served by providing hostel facilities for those children from the outlying areas only when needed to permit full-time attendance at a training centre, i.e., on four nights a week during term times only.

The thoughts expressed in the last paragraph have to some extent been crystallized by the inclusion within the "ten year plan" of a purpose designed hostel for junior subnormals during the year 1964/1965 in West Cumberland. Present indications are that the provision of somewhere about 20 hostel places for juvenile subnormals coupled with some extension of the daily collection programme will be adequate for the needs of the whole county for some years to come. It may well be, therefore, that future developments will tend towards a "run down" of the present provision at Orton Park and its ultimate replacement by a special building in West Cumberland.

(b) **For the Mentally Ill**

After inspecting many possible sites in West Cumberland, in which I was glad to have the advice of the Consultant Psychiatrist in that area—Dr. Gibson—a site of one acre at Bransty, Whitehaven, was acquired during the year. This seems to fulfil many of the locational requirements in that it is within very easy reach of both rail and bus stations, shops, cinemas and other amenities, and yet remains in the "community", there being a municipal housing estate on the opposite side of the road.

Here again a great deal of thought has been given to this new project, and discussions have taken place with all the consultant psychiatrists and with regional representatives of the Ministry of Labour so that the County Architect could be fully informed as to the function of the unit before plans were drafted. The position at the end of the year was that having considered the two extremes of function (short-term for social rehabilitation and temporary support or long-term for those unable to fend for themselves in the community) it was agreed to provide a hostel for 17 people of both sexes for relatively short-term social rehabilitation and resettlement in their normal work.

Attempts to extend the function to include some form of industrial rehabilitation with the assistance of the Ministry of Labour failed because that Ministry had no power to give financial aid except for an approved workshop catering for the employment of registered severely disabled persons of all types. Meetings with senior officers of the Ministry of Labour with special responsibilities for training and rehabilitation at least served to highlight the virtual absence in this area because of geography of those rehabilition facilities which are normally available through that Ministry's industrial rehabilitation units.

Hospital Accommodation

(a) For the Mentally Ill

The policy of providing short-stay units in general hospitals for the treatment of early psychiatric disorders coupled with the further development of arrangements for out-patient treatment and supported by rapidly expanding community care services, aims at reducing the number of hospital beds required for the mentally sick to about half the present number within 10 to 15 years. The relatively small psychiatric unit of 28 beds at the West Cumberland Hospital with its quick turnover of acute cases has had a phenomenal effect in reducing the need for long-term admission of patients from West Cumberland to the Garlands (Mental) Hospital. The new admission unit and its two associated convalescent villas at the Garlands Hospital, providing just over one hundred additional beds, were officially opened in June by Sir George Godber, Chief Medical Officer of the Ministry of Health. This short-stay unit within the grounds of the hospital, which for one hundred years had provided the only psychiatric hospital service for Cumberland, the City of Carlisle and North Westmorland, makes a notable contribution to the psychiatric services of the area.

(b) For the Mentally Sub-Normal

The waiting list at the year end for beds in psychiatric hospitals for the subnormal remains practically at the same level as last year. At the end of the year seven subnormal patients and 40 severely subnormal patients were included on the hospital waiting list. Fortunately only one of these was regarded as being in urgent need of hospital care and this patient has since been admitted. All the remainder are receiving adequate care at home with occasional relief provided by short periods of hostel or hospital care, but their domestic circumstances, age or physical condition, or a combination of these factors indicate the eventual need for admission to hospital. Admissions of the higher grades of patient do not usually present a great deal of difficulty, but the position as regards very low grade patients, especially children, certainly shows no improvement either nationally or locally.

Social Centres and Clubs

The main purpose of social clubs for the mentally disordered is to enable the socially diffident to find companionship with others and thus to restore confidence not only in themselves but in their ability to make contact with others. To this extent the clubs which have been established in Cumberland are basically social rather than theraputic clubs. That they have material theraputic value I have no doubt and indirectly they provide a useful "follow-up" of patients at more frequent intervals and under circumstances differing either from the home or the out-patient clinic.

The evening club for former psychiatric patients of the West Cumberland Hospital, which is held on Wednesday at a junior training centre continues to flourish, thanks to the officers (club members) and the support of the social workers. The afternoon club which was started in the local authority's clinic at Whitehaven to meet the need for those ex-patients who found evening attendance difficult, has restricted its meetings from two to one session each week, so that a better average attendance could be maintained. I am greatly indebted to the members of the Women's Voluntary Service who attend so faithfully to help with the organisation, and who do so much to foster the spirit of social intercourse. Total membership of these clubs remains fairly small because of relative sparcity of population, coupled with the expense and difficulties associated with limited public transport. Small membership is in itself a restricting influence on the range of activities which is possible within the clubs, but they continue in spite of these difficulties to fulfil a most useful function. In an effort to overcome some of the geographical problems the possibilities of opening (and maintaining the necessary minimum membership) of other social clubs in Workington and/or Cockermouth are being explored.

A new evening club was opened in March, 1962, for former patients of the Garlands Hospital. Meetings are held in rented premises in Carlisle every Wednesday evening with the support of the social workers from the hospital and the mental welfare officers. Attendance is open, of course, not only to residents of the City but also to those who live in the county area within reasonable travelling distance of Carlisle and, like the club in West Cumberland, flourishes.

Training and Recruitment

The development of social services is too frequently measured in terms of buildings, but the recruitment and adequate training of staff is in my opinion of much greater priority. To quote the Chairman of the National Association of Mental Health, "Hostels cannot be run without staff, training centres cannot be developed without teachers and families cannot be supported without first class social workers".

The Council has always been anxious to play its part in providing proper training for its staff with the result that Cumberland is much better off than most local health authorities, not only in the numerical adequacy of staff in its mental health service, but in the proportion of trained staff employed. In spite of extensive studies into the problems of recruitment and training, progress in implementing the recommendations (and hence the supply of desperately needed field workers and teachers) is so frustratingly slow that the whole concept of the Mental Health Act is in jeopardy.

The Health Visiting and Social Work (Training) Act, 1962, came into operation on the 3rd July, and authorised the establishment of two Councils, one for the training of health visitors and the other for training in social work. The Council for Training in Social Work in due course will secure that suitable facilities for training are available, and will lay down nationally accepted standards of training in general social work. In anticipation of the requirements of the Council, two year training courses have been established at seven centres, and the authority must consider itself fortunate, in view of the long accumulated demand, in having been able to second a member of the staff (Mr. I. H. Moffet) to one of these "Younghusband type" courses. This is an encouraging start towards the ultimate achievement of a supply of social workers trained to an agreed national standard, but whilst one must be grateful for the initiative of some of the larger educational centres in starting these courses the present output will do no more than fill the gaps created by normal wastage. The present training schemes can make no contribution to offset the acute national shortage of social workers, and certainly are totally inadequate to offer any promise of local health and welfare authorities being able to develop their community care services along the lines envisaged by the Mental Health Act.

In September one of the mental welfare officers (Miss Welch) gained admission under the Council's scholarship scheme to the course of training at Manchester University leading to the Certificate in Mental Health. This took place after a year's delay because of the inadequacy of places at the Universities offering this form of training. By September, 1963, I expect to have two out of seven of the authority's mental welfare staff trained to the level of psychiatric social worker—no mean achievement when it is estimated that two out of every three local health authorities have not a single psychiatric social worker on their staff.

There is as yet no indication of the standards or length of additional training which will be required by the National Council for Mental Welfare Officers already in post who have varying degrees of training and practical experience in social work to qualify them for national recognition. Shortened courses for this type of officer were strongly recommended by the Younghusband Committee, and until the requirements of the Council are known many of the "ad hoc" training schemes which have sprung up from various sources because of the absence of national schemes or standards of training have been discontinued.

The Sub-Committee of the Standing Advisory Committee of the Ministry of Health which was appointed in September, 1959, to advise on the training of staff for training centres for the subnormal, made its recommendations in report form in July. In the main these were for the establishment of a Central Training Council to be responsible for national standards of training, which would be provided through the medium of two year courses. In considering the report the Central Health Services Council recorded the view that it made " a most valuable contribution to the study of the problem" but put a most effective brake on the implementation of any of the recommendations by advising the Minister to start one or more pilot schemes for further research. Meanwhile we shall continue to provide the best form of training which is at present available and that only through a voluntary association.

In September Miss Love returned to duty at the Whitehaven Centre on successful completion of the one year diploma course by the National Association for Mental Health for teachers of the mentally handicapped. Local health authorities must be grateful to this Association not only for its educational efforts over many years in this particular field, but also for pioneering an ever widen-

ing range of courses in many aspects of mental health. This association proposes during 1963 to extend one of its four training courses for teachers of the mentally handicapped from one to two years' duration.

In June, 1962, I was invited to become a member of the Committee of the Northern Branch of the National Association for Mental Health with provision for my Deputy to attend meetings in my absence. I have no doubt that this will prove a helpful link with the principal voluntary organisation in the field of Mental Health.

Staff conferences continue to be held at approximately quarterly intervals for mental welfare officers, for the staffs of training centres and hostel staff. These meetings, though informal, present an opportunity to exchange ideas, to keep abreast of changing trends and generally to discuss the development and improvement of the service.

Amongst the topics discussed during the year were "Supervision of E.S.N. School Leavers", "The Ten Year Programme of the Health and Welfare Services" and "Mental Welfare Officer Oversight of Partial Dependency Dwellings".

Study of Suicide in Cumberland 1951-1960

I am very grateful to Her Majesty's Coroners for East and West Cumberland for their help in connection with a study of deaths attributed to suicide in Cumberland in the 10 year period 1951-1960 inclusive. I hope during the course of this year to submit the findings of this study to one of the medical journals and the following note indicates certain points which can be quoted on initial examination of the collective data.

Suicide Rate

		In terms of rates per million	
		Cumberland	England and Wales
MALES	112	102.3	142.3
FEMALES	52	46.9	83.0

(The Cumberland suicide rate is considerably lower than the national rate.)

Marital Status		Age		
Married	86	Under 20	2	(both aged 18)
Single	50	20 — 29	15	
Widowed	25	30 — 39	14	
Divorced	1	40 — 49	26	
Not known	2	50 — 59	53	
	164	60 — 69	28	
		70 — 79	19	
		80 +	7	
			164	

The comparatively high rate of suicide between the ages of 50 and 60 shows the same trend as do the national statistics.

Causes of Death	Total	
Poisoning by analgesic and soporific substances	15	
Poisoning by other solid and liquid substances	3	
Poisoning by gases in domestic use	57	
Poisoning by other gases	1	
Hanging and Strangulation	39	
Submersion (drowning)	23	
Firearms and explosives	15	
Cutting and piercing instruments	5	
Jumping from high place	3	
Other and unspecified means	3	(all struck by train)

The two most common causes of death, poisoning by gases in domestic use and hanging and strangulation are also indicated to be the commonest when the national statistics are studied.

Occupation

There is a wide range of occupation, and no significant trend was observed.

SECTION 29

HOME HELP SERVICE

No. of home helps accepted and enrolled on the register at 1st January, 1962	238
No. of home helps accepted during the year	44
	282
No. of home helps resigned during the year	29
	253

Districts in which the Home Help resides :—

	1962	1961	1960	1959	1958
Alston	11	11	12	12	11
Aspatria	13	13	16	13	15
Border Rural	41	44	41	44	45
Cockermouth	4	4	4	3	2
Ennerdale	34	31	31	31	31
Keswick and Threlkeld	10	7	5	6	7
Maryport and Dearham	14	13	9	10	12
Millom	22	22	19	19	15
Penrith and Penrith Rural	33	26	25	25	26
Silloth and Mawbray	11	9	12	10	13
Whitehaven and Distington	18	18	17	19	13
Workington	22	25	24	25	22
Wigton and Fletchertown	20	15	14	10	17
	253	238	229	227	229

Householders—	1962	1961	1960	1959	1958
No. of applications received for home helps	561	536	504	447	455
No. cancelled or not supplied ...	176	179	175	152	175
No. of new cases helped	373	333	313	270	268
No. of cases on books 1st January, 1962	573	544	509	454	414
Cases pending	18	24	21	18	17

Analysis of Cases Helped—	1962	1961	1960	1959	1958
Confinements	79	57	60	45	45
Tuberculous cases	7	9	13	12	10
Old age and infirmity	554	505	492	421	391
Mental Health	6	2	—	1	3
Cardiac	74	81	62	53	56
Blind	30	30	28	29	22
Cancer	10	7	4	7	5
Illness of long duration (cerebral haemorrhage, rheumatoid arthritis, etc.)	112	115	98	91	91
Illness of short duration (post operative, influenza, etc.) ...	74	71	65	65	59
	946	877	822	724	682

In each area meetings of home helps are held at which problems are discussed. In addition 2,553 visits were made to householders and home helps.

"A Local Health Authority may make such arrangement as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill—lying-in, expectant mother, mentally defective, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944."

This was the starting point in legislation of the Home Help Service as we know it to-day; a service which has come increasingly to contribute an unobtrusive but indispensable part to the domiciliary health service. At present there are 253 home helps in the county, of whom 24 are full time and the remainder part time with duties ranging from 3 hours on one day a week to 4 or 5 hours on six days a week. Where a confinement case requires full time help the total hours are 42 a week. The figure of 253 home helps compares with 106 in 1949 and 198 in 1956, and illustrates the growing importance of the service. The cost was £3,789 in 1949 and £22,700 in 1956, and to-day is £41,000, a steady and impressive build up despite increasing costs due to rising wages. That this service must continue to expand there can be no doubt—if for no other reason than the continuing rise in the proportion of elderly people in the community.

This expansion continues in evidence in 1962, the number of households helped showing an increase of 69 over 1961. The majority of these are accounted for by old age and infirmity and confinement.

The nurses and health visitors continue to give valuable help in visiting householders and arranging for the home help to attend, particularly when an emergency arises. Being in the locality they can deal with this very quickly, allowing an emergency midwifery case to go to hospital without concern about someone to look after the children.

The provision of a home help enables many of the old people to stay at home for as long as ten years until they become too feeble to do their own housework and look after themselves personally. They are most appreciative of this service; most of them realise that they would have had to leave their own homes much earlier had the home help not been available. Throughout the year the home helps have given valuable service, often doing more than is required of them in order to help the old people to whom they become very attached. It is always difficult when changes have to be made for the benefit of the service as a whole. People do not like change, but after a visit of explanation they usually settle down quite happily with someone new.

It is more than a year since the flatlets for old people with welfare facilities were opened at Keswick, and it has been found necessary to supply a home help to six of the householders. I find, however, that with the amenities supplied at the flatlets the home help is only required on an average twice a week. In one case there is an elderly lady of 92 who has required daily help so that she could have her breakfast in bed and a mid-day meal prepared for her. To begin with one home help was allocated to do the work in the flatlets, but it may become necessary to allocate a second home help as more householders require help owing to their advancing years.

Several of the old people living in and around Wigton moved into the Grouped dwellings with welfare facilities where there is a warden with oversight. A communal lounge with television is provided. The home helps were able to help these old people to move in and cope with the problems arising when an old person is moved from a home of many years standing to a new residence. After a few teething troubles with the firegrates, and the understanding of new cookers, they all settled in happily.

There has been an increase in the number of confinemer cases attended which may be due to the popularity of the servic or possibly to the increase in the birth rate. It is obvious that th mothers appreciate the benefit of this service, and the help give them whether the baby is born at home or in hospital.

During the summer meetings were held in various parts of th County:—

Millom	Penrith
Whitehaven	Silloth
Workington	Alston
Wigton	Carlisle

The work was discussed and home helps' questions wer answered. A film-strip on the new method of resuscitation — mouth to mouth breathing, was shown and discussed. In previous years films and discussions, including "The Prevention of Acci dents in the Home", "Diet for Old People" and "Welfare Services Available for Old People".

Re-organisation of the work is under discussion which wil enable the Nursing Officers in West Cumberland to check the time sheets for the home help in their area, and also have at hand an accurate record of the hours worked and the time spent in travel ling.

What of the future? There are areas in the county where it is difficult to get home helps on account of distance and lack of transport, and there are some households that do not have ade quate facilities. Is the answer here the promotion in these areas of village home helps who will be given a small retaining fee when their services are not required? One also wonders if the provision of a central washing unit will be the answer in Urban areas such as Penrith, Wigton and Aspatria.

The problem of balancing reasonable expenditure against adequacy and comprehensiveness in the service remains, and social thought is constantly being injected into the planning of a service so critical in enabling the realisation of home care in so many differing conditions.

WELFARE SERVICES

The first full year of the Health and Welfare Department, as such, has been one of considerable activity. This has centred principally on the establishment of lines of communication with other related services; the implementation of Ministry of Health Circular 2/62 in the form of a 10 year programme, and of circulars 7/62 and 18/62 on voluntary work; the closure of Meadow View House in conjunction with the opening of two new Old People's Homes; and an important re-orientation and clarification of the views of all concerned with the residential care of the elderly. These main lines of the work have, of course, become closely interwoven as the following more detailed report on each of the main topics will show. Possibly the main effort in 1963 has been concentrated on the elderly and their needs in terms of direct action and provisions, while the services for the handicapped have been more under study with a view to clarifying thought on the way ahead in this field. Nevertheless, much of the picture of the needs of the elderly has still to be painted, and it is with this in mind that I am at present planning a survey of a sample of persons over 75 in the county. I expect this to be undertaken, at the expense of considerable time and effort, this year, but I am sure that only facts so revealed can give confidence in planning services.

Homes for Elderly People

I outlined in my report last year the basic concepts and principles which I regard as fundamental to providing the necessary range of "homes" for the elderly, catering for varying degrees of dependency, and at the same time meeting the wishes as well as the needs of each old person. With regard to old people living in their own homes, it has proved very difficult to establish anything like a comprehensive register of names in any area; a register which, amongst many other valuable things, would help to produce a clearer picture of the social conditions under which the elderly Cumbrian lives. This result, I believe, can be achieved by means of the survey of over 75s referred to above. Nevertheless, progress has been made in bringing the field nursing staff further into touch with the care of the elderly at home. It will be apparent from the account given earlier in this report on the home Nursing Services that a high proportion of nursing visits are made to the elderly on purely medical grounds. The nurses realise that their responsibilities to these "patients" are wider than their

immediate medical needs, and span the whole area of medico-social services and health education. Similarly Health Visitors seconded to General Practitioners (now 17 of the 24 full-time health visitors) are particularly well placed to be in close touch with their "flock" of ageing people to whom they have much to offer. During the year an Old People's visiting card has been introduced similar to the child visiting card with which the health visiting staff have become so familiar over the years. Although only a percentage of these have actually been completed, many more old people are known to be receiving visits from the nursing staff. I am giving considerable thought at present to the position of the nurses vis-a-vis the "Welfare Officer" of the future. It may well be that in a county such as Cumberland a limited staff of the latter will have a special responsibility for handicapped persons with special needs, the more purely administrative aspects of old people's care, and arrangements for admission to homes as well as the supervision and co-ordination of welfare services to the elderly in their own homes and in Grouped Dwellings with welfare facilities. A beginning has already been made in this direction by the appointment to the first such post of the Ex-Manager of Meadow View House, Whitehaven. There are, of course, still nine part-time welfare officers (amounting to two full-time equivalent) whose duties are almost entirely confined to financial and other assessments in connection with admission to Residential Homes.

The next stage of dependency with regard to elderly people living in their own homes is catered for by the conditions provided in Grouped bungalows and flatlets with warden oversight. Three such schemes are already in operation in the county, at Keswick, Wigton and Dalston, and three more are planned to come into use in the next twelve months. Those at present functioning provide for 68 people, and each of the future schemes will provide for approximately 20-25 more. That such schemes have a secure future there can be no doubt whatever, although it is very apparent that careful selection of tenants is necessary, and the smooth mobilisation of the whole range of welfare services for these tenants must be ensured from the start. I view the place of the District Medical Officer of Health, who is also an Assistant County Medical Officer, as crucial in this type of scheme and I am increasingly looking to him to lead the welfare team locally. According to the present agreement with District Councils the latter employ the warden, though her payment is met in full by the County Council as Welfare Authority. An amendment to this

scheme is at present being put to the various District Councils with a view to the warden being the employee of the County Council and being more completely integrated to the welfare services necessary for the elderly tenants. Arrangements are going forward for each warden to have constantly by her comprehensive and up-to-date information on all of the services which can be called upon from the Health and Welfare Department, including Health Visitor, District Nurse, Mental Welfare Officer, etc. The first full-time Welfare Officer appointed, to whom reference is made above, is at present taking a particular co-ordinating interest in the provision of welfare services for grouped dwelling tenants. The selection of these tenants and the selection of the warden are by joint agreement between the District Councils and the County Council. Reference was made last year to the variant of the scheme which is planned for Alston whereby a small Partial Dependency Unit will be combined with a small residential home —the District Council and the County Council working together on this project. Similar schemes are now planned for Aspatria and Longtown within the next three years and the building at Alston should be completed at the end of 1963.

As each Grouped Dwelling scheme is planned or comes into use, features of the buildings and services which can be improved are coming to light, and thus each scheme shows improvements in detail on earlier ones. For example, an efficient intercom. arrangement has been introduced to the Dalston scheme for the first time. It has already been illustrated in the County how one individual tenant can give rise to a great deal of anxiety where his or her handicap proves more formidable than was anticipated when the selection of tenants took place. One elderly lady, who was both severely deaf and has very impaired vision, but is nevertheless extremely independent, has given many hours of anxiety to all concerned with her welfare.

The whole concept of grouped dwellings with warden oversight and a full range of welfare services ranged alongside is one of the most interesting challenges in the care of the elderly, and it is being well met in Cumberland by the District Councils and the County Council in partnership.

The Provisions of Residential Homes for the Elderly (Part III, National Assistance Act) passed an important historical milestone in 1962 with the closure of Meadow View House at Whitehaven, and the forward planning of Homes for the next ten years.

Meadow View House was the largest and oldest of the Public Assistance Institutions in the County.

The Poor Law Amendment Act of 1834 set out a pattern of care for the poor and destitute in terms which are themselves so foreign to the ear of the mid-twentieth century that it is not surprising that the buildings erected to meet this legislation are equally out-dated by present day standards. The workhouse atmosphere of those days was immortalised in "Oliver Twist" four years after this Act went on the statute book. Meadow View was built only sixteen years after that, in 1854.

In its earliest years the workhouse, as it was then called, was administered by the Board of Guardians of the Whitehaven Union. Legislation and control changed several times in the evolution of social services; the first major change followed the Local Government Act, 1929, when in 1930 institutions such as Meadow View became vested in the County Council as Public Assistance Authority.

Though the words changed to "social welfare" and later to "welfare" and the help offered to those in need of care was progressively humanised, little could be done with the stones and mortar. The National Assistance Act of 1948 was intended to eliminate the last vestiges of the Poor Law approach, but still buildings such as Meadow View persisted and not until the worst of these are eliminated can we even expect the public to stop speaking of certain places as "the old workhouse".

It was felt by the Cumberland County Council's Working Party's Report of 1959 on the care of the elderly that no amount of upgrading by way of building improvements could bring Meadow View up to required modern standards. Such features as windows were inadequate by to-day's standards, while others such as stairways were dangerous for elderly partly infirm people. It was therefore recommended that Meadow View should be closed down as soon as possible when new type homes were built. This recommendation was accepted by the County Council in Vol. 71, page 994, Min. 86, and new homes were planned for Egremont, Workington and Brampton.

It was foreseen in the Working Party's report that the residents at Meadow View could not be transferred "en bloc" to the new homes as it had for long been recognised that a number were in

he "difficult" group. The tendency in recent years, because of he new general use of the tranquillizer group of drugs, has been for such so-called anti-social residents to show less behaviour problems than previously. However, at Meadow View, there were quite a number of mentally sub-normal residents, often with associated physical conditions such as epilepsy, who mainly represented the group I refer to as "difficult". My feeling that the impact of the environment of a small home upon the "difficult" group has been under estimated, has, I believe, been amply confirmed.

A preliminary survey suggested that probably about 30 of those now at Meadow View could be considered suitable for transfer to new homes and indeed all residents were given an opportunity of saying which of the homes they would like to enter. Similarly those residents who might wish to move from the existing modern homes to Egremont or Workington were given careful consideration, and, where possible, their wishes granted. The result of such moves was to leave 46 places available in the modern homes and most of these were filled by transferring suitable residents from Station View House, Penrith, and Highfield House, Wigton. Here again the wishes of the residents were taken into account. The vacancies so created there were filled from Meadow View.

The new Homes at Workington and Egremont which cater for 38 residents were opened on 10th October, 1962, and 29th November, 1962, respectively, and the closure of Meadow View House was effected on 10th October, 1962, with very little upset to those residents who were transferred from one Home to another. To meet the fairly complicated procedure of closing so large an institution, the whole exercise occasioned a considerable amount of extra and painstaking work for both the staffs of the Homes and the clerical and administrative staff of the Welfare Section of the Department. This was undertaken willingly and carried through admirably.

The following fascinating commentary on the transformation from Meadow View to Richmond Park is contributed by Mrs. Lewthwaite, Matron of Meadow View House for 6½ years, and now Matron of the new Richmond Park Home, Workington.

"On the 10th October dinner was served at 12 noon to the residents at Meadow View House, and at 5 p.m. they, 31 residents,

sat down to high tea at Richmond Park, Workington. This was indeed an exciting and hectic day for residents and staff. Perhaps the day did start with an air of apprehension among the residents, but I may honestly say that when it was evening, and after their first meal, on going into a lounge, one could hear chatter and laughter and the impression one got was that this new building had been occupied for weeks and that these people felt quite at home.

Surroundings do have an effect on people — I find that the residents' life here is fuller than at Meadow View House; close to shops, schools and traffic there is always something going on. Visitors pop in and out at all times, even at breakfast time, when a grandchild came in on her way to school to bring her grandma a gift, and to wish her a happy birthday; this helps to create a homely atmosphere. One of the "old boys" 89 years of age, who never went out at Meadow View House, takes a stroll down the street now because the shop and post office are nearby.

At Meadow View House the men and women were separated; here at Richmond Park, for the first time, men and women mix freely and it has proved a good thing. Because of the close proximity of churches, buses, clubs—and even public houses, we find our people are more a part of the community here than at Whitehaven. How times change — relatives are no longer ashamed of having parents in welfare homes — in fact they are inclined to boast about how comfortable mother or father is, and every day we have people asking for vacancies. Single and double rooms are a boon in comparison to the dormitory type rooms of institutions. I do know that none of our residents would wish to return to Meadow View House now."

The new Homes at Workington and Egremont have been the objects of much comment by the Press and Public which are becoming increasingly conscious of the needs of the elderly, and of the considerable amount of effort and planning which is being directed this way by the County Council. A preview of each of the Homes was arranged, particularly for the doctors and hospital staffs in the areas, immediately before the Homes opened, and soon afterwards an open day was held when all interested were invited to view the Homes. These events were undoubtedly successful, and have stimulated considerable interest generally in the welfare of the elderly.

The ten year programme required by the Ministry of Health under Circular 2/62 has provided for 2.5 places in residential homes per thousand population in Cumberland in the ten year period. The forward plan for residential accommodation is shown as an appendix to this report, and considerable thought is being given at present to the possibility of bringing forward the year of closure of Highfield House, the next of the ex-P.A.I. buildings scheduled to be closed as soon as possible as Part III accommodation. I believe that the County Council's plans in this field would compare favourably with those of any part of the country in terms of both quality and quantity of provision.

" The plan provides for the following :—

1962/63	Brampton (new home), 25 places. Alston (new home), 10 places (in association with old people's flats for 10 persons).
1963/64	Longtown (new home), 10 places (in association with old people's flats for 10 persons).
1964/65	West Cumberland (new home), 40 places for the more infirm. Aspatria (new home), 10 places (in association with partial-dependency flats).
1965/66	West Cumberland (new home), 20 places for younger handicapped persons. Keswick (new home), 25 places. Cockermouth (replacement), 40 places (and replacing Derwent Lodge, Papcastle).
1966/67	Tarraby, near Carlisle (new home), 40 places.
1967/72	Wigton (replacement), 40 places (replacing Highfield House, Wigton). Whitehaven (new home), 40 places. Ennerdale (new home), 25 places. Penrith (replacement), 40 places (replacing Station View House, Penrith) "

In parallel with the years developments as described above, and the acceptance of the important principle of neighbourhood care for the elderly there has been a fundamental re-appraisal of the basic purpose of a residential home for old people, and of the principles which should guide the staff in caring for the residents. On the more purely physical plane the primary objects are the alleviation of the limitations and frustrations imposed by physical disability, and the prevention, as far as is possible without resident nursing care, of the need for transfer to hospital; while there has been set before the staffs as a guiding star for the future the broader orientation of life towards a real sense of security, a feeling that a new phase of life is opening up with new interests and

an outward looking attitude towards the community rather than a sense of confinement within the restrictive circle of the Home itself. The Health Committee decided that all restrictive rules in the Homes should be eliminated and provide the following pattern of approach to residents.

(i) A simple, friendly letter of welcome will be sent to each person to be admitted to a Home. This would be in addition to the personal visit from the district welfare officer to arrange the admission.

(ii) The matron will give at least an hour's personal attention to each new resident on arrival so that they may be made to feel at home straight away.

(iii) Where it is necessary for the authority to arrange transport for a new admission it will be through a voluntary body if at all possible.

(iv) As part of the "settling-in" process, new residents may have a thermos flask of hot tea when retiring to bed, as they may well sleep badly on the first night, and will have breakfast in bed on the first morning.

(v) The older residents, for example, those in the ninety year old group and others in appropriate groups, will be encouraged to stay in bed on, say, one day a week rather than dozing uncomfortably in chairs.

(vi) Every mentally fit old person should have a job about the Home without any monetary reward.

(vii) All will be encouraged to take up some hobby and the provision of a special hobbies room in future Homes will be considered.

(viii) All visitors to Homes will be made welcome, a cup of tea provided for them.

(ix) The further brightening-up of homes by providing hanging baskets and plants in the halls, and the provision of a vase of flowers in the bedrooms to welcome a new admission; and

(x) Each resident can have in his or her room some article of furniture which can be regarded as personal.

(xi) From time to time night sitters are needed in the homes and quite a strain is imposed when the existing staff have to undertake this. Every effort will be made to recruit night sitters from voluntary bodies.

At Parkside Home, Maryport, a handicraft instructor visits weekly and is building up quite an interest amongst many of the old people, while at the same Home the first experimental club in the County was started during the year and is progressing most successfully. At present 15 old people recommended or approved by the Health Visitor or District Nurse attend once per week for lunch at the Home, and stay on to mingle with the residents before going home later in the afternoon. Valuable help with transport is given by the Women's Voluntary Service. A similar arrangement is also being established for the new Egremont Home, and will probably, I believe, figure even more largely than the very valuable Meals on Wheels service provided for so long by the W.V.S. There will always, of course, be a need for the latter service.

At The Croft, Millom, handicraft work has now been made available in the form of light craft in felt, wool and other light materials. This is under the guidance of Mr. Robinson, Handicraft Instructor, based at Workington and he reports that a small group of three ladies are making the pace and the project shows every sign of becoming very popular.

Another matter which has interested me considerably of late is the dental state of the old people in the Homes. Mr. Neal, Principal Dental Officer, has kindly surveyed the residents in one of the County Council's Homes and it was found that approximately 74 per cent. of the people require dental treatment in some form but it can be assumed that only about 60—65 per cent. of these would benefit. It is clear therefore that this question will require to be gone into further to ensure more comprehensive care for these elderly people.

Thoughts for the future with regard to Homes for the Elderly are their asscoiation with Day Hostel facilities, and the interesting possibility of the erection of a voluntary annexe beside the Old People's Home. Discussions on both these matters have been commenced with the various interested parties, and I look forward to having more to say next year about the progress of these ideas.

The following two tables show the increasing use of Homes as against the joint user establishments and the pattern of beds available in the Homes.

Available Beds and Occupancy

At 31st December	No. of beds provided			No. of Residents		
	Joint-User Establish-ments	Home	Total	Joint-User Establish-ments	Home	Total
1952 ...	325	—	325	217	—	217
1953 ...	325	19	344	201	18	219
1955 ...	263	69	332	188	57	245
1958 ...	242	87	329	193	88	281
1959 ...	252	108	360	199	99	298
1960 ...	215	146	361	174	132	306
1961 ...	215	146	361	178	132	310
1962 ...	117	230	347	93	208	301

It should be noted that the overall slight reduction in the number of places in the Homes at the end of 1962 is a temporary feature associated with the beginning of a new stage in development of Part III Accommodation. These places which appear to have been "lost" were in fact previously part of the unsatisfactory accommodation at Meadow View House, where there was always a very understandable reluctance on the part of many people to take up the places available. A high bed occupancy in such old establishment was always difficult to achieve because of the environmental and ecological situation associated with these Homes. The development of the 10 year programme now commenced will soon provide for the largest number of residential places which has ever been available for old people in the county. These will increasingly be situated in modern purpose built homes with the elimination at the earliest possible date of the remaining joint user establishment accommodation.

Table of Available Beds and Age Groups in Modern Type Homes

Home	4 bedded rooms	3 bedded rooms	2 bedded rooms	Single rooms	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Total No. of Residents
Grange Bank, Wigton— Opened 1.4.53.	12	6	—	1	19	—	—	—	—	—	—	1	3	2	11	—	17	17
Derwent Lodge, Papcastle— Opened 1.1.55.	8	6	4	—	18	—	3	12	1	—	16	—	—	—	—	—	—	16
Garlieston, Whitehaven— Opened 1.11.55.	12	18	—	2	32	1	1	4	8	2	16	—	2	6	4	1	13	29
The Croft, Kirksanton— Opened 1.3.58.	—	6	10	2	18	—	4	3	1	—	8	—	2	1	6	—	9	17
Parkside, Maryport— Opened 16.5.60.	—	—	18	20	38	2	2	10	2	—	16	1	2	9	10	—	22	38
The Towers, Skinburness— Opened 1.8.58.	12	—	8	1	21	2	3	7	—	—	12	—	2	4	4	1	11	23
Richmond Park, Workington— Opened 10.10.62.	—	—	18	20	38	4	6	9	3	2	24	2	3	8	1	—	14	38
Castle Mount, Egremont— Opened 29.11.62.	—	—	18	20	38	—	6	6	2	2	16	1	2	5	6	—	14	30
																TOTAL		208

The following table shows the number of admissions dur the year. New admissions show an increase of 25 over the p vious year, the large number of transfers is due to the closure Meadow View House, Whitehaven.

Admissions during year ended 31st December, 1962

	New Admissions	Transfers from other Homes	Re-admissi after holid or hospit
Station View House ...	20	4	11
Highfield House ...	25	22	26
Grange Bank ...	5	2	1
The Towers ...	7	22	2
Derwent Lodge ...	2	6	9
Parkside ...	5	10	11
Richmond Park ...	12	34	2
Garlieston ...	3	11	11
Castle Mount ...	11	20	—
The Croft ...	2	4	8
Meadow View House ...	53	4	12
	145	141	93
Year to 31st December, 1961 ...	120	30	107

Registration of Private Disabled Persons or Old People's Homes

There are three such homes registered in the County, viz.:—

Seaton Villa, Seaton	... 8 persons
Stoneleigh, Gosforth	... 11 persons
Rothersyke House, Egremont	... 14 persons (increased from 10)

Regular inspections are made.

Temporary Accommodation

The unit at Highfield House, Wigton, has been brought into use and during the year evicted or homeless families have been accommodated for varying periods. Others have been provided with Part III accommodation in Meadow View House up to its closure and later in Highfield House, Wigton.

Evicted Families on becoming homeless for other reasons are becoming an increasing problem and it is hoped that after consultation with local housing authorities "intermediate accommodation" might with financial support from the Council be made available.

Handicapped Persons

Although less that is new in thought or fulfilment has been introduced in 1962 in the services for the handicapped, the existing services have made progress and two important events occurred in the field of blind welfare, namely the transference of five home teachers of the blind from the Cumberland and Westmorland Workshops for the Blind to the direct employ of the County Council, and the passage of control and administration of the Workshops for the Blind to a joint Carlisle and Cumberland Committee, to which I am responsible as Executive Officer.

Regular meetings of the five home teachers have been arranged within the department at which all aspects of their work have been reviewed and liaison established with the other sections of the department, namely, Nursing, Mental Health and School Health, as well as with the Ministry of Labour and the Hospital Almoners. This has been further developed by arranging for the Home Teachers to meet nursing and other staff at their regular staff meetings and "in the field". Contact has also been established with the consultant ophthalmologists at their clinics.

Miss Mitchell, one of the home teachers takes a historical look at her work and gives an interesting commentary as follows::

" Home Teachers have been visiting and teaching blind people to read the Bible by means of embossed print since 1834 and guides provided to take people to church. A scheme was developed in those days for helping a few blind men to make goods in their own homes and this is now called the Home Workers Scheme.

Braille and Moon later became known and these two systems are now accepted universally with books on every subject available. These are provided free to members of the National Library for the Blind, postage being prepaid at special rates instituted at the beginning of the 1900's when we had a blind Postmaster-General.

Up to the early part of this century there was no Government legislation for the welfare of the blind. This is now taken care of by the 1948 National Assistance Act which transferred the duty of financial assistance from the Poor Law to the National Assistance Board (the N.A. scale for blind people provides a higher rate than for sighted) and welfare to the Local Authority. In this Act Home Teachers must be provided by each Local Authority to visit the blind in their area and in this County the number of Home Teachers is five.

Their duties are varied:—

Initial discovery and ascertainment of the needs of a blind person.

Visiting at home, institutions, prisons or any place where there is a registered blind person.

Teaching Braille and Moon and various handicrafts.

Organising social clubs and handicraft classes.

Care of the deaf-blind and partially sighted.

People of employable age are encouraged where possible to attend a rehabilitation centre at Torquay before training to become shorthand typists, physiotherapists, telephonists, or workers at one of the workshops for the blind. Others over employable age, also housewives, attend Oldbury Grange, where the housewives learn to cope with everyday household duties.

General health and living conditions are supervised, arrangements made for chiropody treatment or extra help in the home. Wireless sets are provided through the Home Teachers via the Wirless for the Blind Fund, also free wireless and dog licences. Talking books with records similar to long playing records are available for the housebound or aged blind.

Apparatus supplied by the Royal National Institute for the Blind can be provided covering such items as kitchen equipment, literature, maps, writing appliances, toys, games, which are sold at only part cost to a registered blind person. Information is often given on guide dogs, or on medical or surgical treatment which may have been suggested.

Young children not yet of school age are visited and parents helped with the early training of a blind child, to ensure that he or she is brought up as a normal member of the family. Later embossed books can be provided and outings arranged during school holidays so that the child does not miss too much the companionship of school friends."

Handicraft and Social classes have been held regularly throughout the year at Penrith, Whitehaven, Egremont, Workington and Millom, and the Barrow, Furness and South Cumberland Association for the Blind continue to act as agents for the administration of welfare services for the blind in Millom.

Miss Hetherington, who has care of 76 blind and 18 partially sighted people, gives an interesting account of the handicraft and social club activities at Penrith.

"Handicraft Class" is held weekly at Penrith, attended by 8 people. Knitting, basketry, leatherwork, rugs, sea-grass stools and chair-caning are the main crafts taught. In the social shows of 1962, these members took twelve 1st prizes in the "handicapped classes". We were congratulated on our display and special mention was made in the Press.

Apart from the classes, 8 people are being taught in their homes, chiefly knitting. One lady, aged 93, is knitting dish cloths and is very proud of her achievement.

The Social Club consists chiefly of class members. The peop of Penrith are very good about coming to entertain, but somehc these blind people prefer to do the entertaining themselves. Mc of the club are members of the Penrith Evergreens, and it giv them great joy to be allowed to invite four members from th club down to their own club. The latest craze is dancing, a they intend to go ahead with this, hoping one day to learn Scotti dancing and to enter for competitions.

Out of their own funds, the club had two outings in th summer. The St. Bees outing was enjoyed, but the other outin calling on blind people, was enjoyed even more.

Visiting

Cases are visited regularly. Cigarettes, fruit or sweets a taken each visit to blind people in hospital, County Counc Homes, elderly people or any sick person in their homes. A vis to these people is greatly appreciated.

Reading

Braille is not very popular. However, one man from Wigto is making splendid progress and hopes, one day, to qualify as Braille-copyist.

Moon. Two people have recently mastered Moon-reading one of them is now a member of the Manchester Library.

Home Help Service is a great boon to many blind people.

Wireless Sets. All have sets, some require replacing."

Since the Workshops and Hostel for the blind have becom a direct responsibility of the two Local Authorities considerabl thought has been given to the future of both the Workshops an the Hostel. This has centred mainly on the activities of the former and on the general unsuitability of the latter building for it present purpose. It is in some way a fortunate coincidence tha in December, 1962, the report of the Ministry of Labour Workin Party on Workshops for the Blind was published setting out th prinicples which will probably guide Workshops development fo the future. An indication of the extent to which this report ha been accepted and endorsed by the Government is now awaite with considerable interest.

Blind, Partially Sighted and Deaf

New Registrations

During the year 58 persons were certified to be blind and 16 partially sighted. These fell in the following:—

Age Group	Blind			Partially Sighted		
	M.	F.	Total	M.	F.	Total
0— 4 ...	—	—	—	—	—	—
5—15 ...	—	—	—	—	1	1
16—20 ...	—	—	—	—	—	—
21—49 ...	1	1	2	1	—	1
50—64 ...	3	6	9	2	4	6
65 and over ...	20	27	47	3	5	8
	24	34	58	6	10	16

Register

The total number of blind and partially sighted persons registered on the 31st December, 1962, are classified as follows:—

Certification of Blind and Partially Sighted Persons on Register at 31st December, 1962

Age Group	Blind			Partially Sighted		
	M.	F.	Total	M.	F.	Total
0— 1 ...	—	—	—	—	—	—
1— 4 ...	—	1	1	—	—	—
5—10 ...	4	1	5	3	—	3
11—15 ...	3	3	6	5	4	9
16—20 ...	3	—	3	7	1	8
21—29 ...	7	2	9	1	4	5
30—39 ...	11	6	17	3	1	4
40—49 ...	16	14	30	3	5	8
50—59 ...	20	19	39	10	5	15
60—64 ...	16	23	39	3	8	11
65—69 ...	21	40	61	5	7	12
70 and over ...	105	198	303	17	35	52
	206	307	513	57	70	127

Deaf and Hard of Hearing

Agency arrangements have been continued with the Carlisle Diocesan Association for the Deaf for the provision of the welfare services for the deaf.

The whole area covered by the Association comprises the counties of Cumberland and Westmorland together with the Furness district of Lancashire and the County Boroughs of Carlisle and Barrow. The Association's field staff consists of two male and one female qualified Welfare Officers for the Deaf and one part-time home visitor. A service of interpretation has been available at all times to help the deaf and those with whom they have dealings.

The number of deaf people in the County of Cumberland analysed for return to the Ministry of Health on 31st December, 1962, were as follows:—

	Ages 16 — 64	Aged 65 and over
Male		
Deaf without speech ...	35	10
Deaf with speech ...	9	2
Female		
Deaf with speech ...	7	—
Deaf without speech ...	26	3
	77	15

Total 92 persons

The social needs of these people have been provided for in the Handicapped Persons Social Centre in Workington and at the Institute for the Deaf in Carlisle. The Association also maintains an Institute in Barrow which helps to serve deaf people in South Cumberland. All the deaf people have been seen regularly, whether at the Centres or in their own homes, and have been helped with personal problems. Extra time has been given to the visiting of deaf people with mental illness and interpretation has been made available to psychiatrists in their clinics.

During the recession in industry it has been more difficult to find employment for deaf people. The staff have co-operated fully with the officers of the Ministry of Labour.

In each Centre regular religious services have been conducted in the combined method of communication generally used by the Deaf.

Special attention has been given to the needs of young deaf people and with the help of the Cumberland Education Committee and staff, courses in out-of-doors activities based on the County Youth Centre in Keswick have been continued.

The Association's Annual General Meeting 1962 was held at the Handicapped Persons Social Centre in Workington when the visiting speaker was Dr. E. S. Greenaway, O.B.E., B.Sc., D.Litt., Headmaster of the Yorkshire Residential School for the Deaf in Doncaster and also Chairman of the British Deaf and Dumb Association. County Councillor Miss J. E. MacInnes was re-elected Chairman of the Association. Cumberland County representatives on the Committee are Alderman Mrs. E. G. Cain and Councillor C. Ritson. Mr. S. Hodgson, County Welfare Services Officer, was also re-elected as a member of the Committee.

Handicapped and Disabled Persons

The Workington Centre and Social Club for handicapped persons which opened in November, 1961, was extensively used during the year by the handicapped, the blind and partially sighted and by the deaf. Craft classes and small gatherings are held every week, and the availability and resources of these premises is very much appreciated by everyone associated with it. The Millom Centre, which came into use on 23rd February, 1962, meets a similar need in that area.

Mr. Robinson, Handicraft Instructor, writes as follows on these activities.

" The Social and Craft sessions now cater for a wide range of Handicapped Persons. Those unable to make their own way to the Centre are conveyed by Health Department transport covering an area bounded by Bullgill, Cockermouth and Kells. The Social session attendance averages over 20 persons, but tends to fluctuate owing to the varying degrees of fitness of the individual. Games are provided and include Dominoes, Draughts, Cards and Snooker. An excellent Television Set has been installed for the use of all who attend the Centre. Local artistes frequently attend to entertain and refreshments are provided by the Handicapped people themselves.

The Craft session was formed from a small group of keen handicapped people with some experience in Craft. Basic techniques were taught to this group who in turn have now become key

people, as keen, but inexperienced handicapped people are included in the session. From the original four persons, this Craft group now attracts no less than eighteen people with numbers rising each month. Owing to the size of the building and with one Craft Instructor a 'ceiling' of possibly 25 members may have to be imposed. A volunteer Craft worker would be more than welcome, and this would increase the time that could be given to individual tuition. At the moment such tuition is limited to five minutes per person. Craft instruction at the Centre now covers:—

Basket Work; Simple Leather Work; Seagrass Stool weaving and Bag making; Light Woodwork in the form of Picture Framing and simple turning of such things as table lamps on a newly installed lathe. The lathe has proved extremely popular, and it is envisaged that eventually the handicapped people will turn their own stool legs and thus be able to build the project from the raw material to the finished product.

The Millom Centre operates for a smaller group at a mixed Social/Craft session on Thursday afternoons: in the Millom area there has been a little more difficulty in stimulating interest in these activities—due in part at least to an apparent reluctance on the part of the handicapped people in this area to acknowledge their disability by attendance at the Centre.

The year 1962 has been one of building traditions in the new Handicapped Centres. People from all walks of life who have previously been house-bound for years, now congregate with a facility that is most encouraging.

They have their own Committees and organise the occasional Coffee Evening and Rummage Sale. The proceeds of their 1962 efforts were used for a first ever Handicapped Persons trip to Dumfries and Kirkcudbright."

Register of Handicapped Persons

The register of handicapped persons kept in the department is gradually being brought up-to-date with the help of the District Nurses and Health Visitors. An up-to-date assessment of the physical condition and social circumstances of each of the persons whose name at present appears on the register is being made, and many cases have been deleted as no longer requiring the special-

ised type of assistance for which the register is primarily kept. This involves many people who have passed into the elderly group, and in whom employment problems no longer figure as in their earlier years. For such elderly handicapped people an old person's visiting card is being completed and passed to the appropriate nurse for visiting as required. In other cases it is found that a less severe handicap, originally registered has been for all practical employment and social purposes, overcome, and no longer requires any specialised supervision. Such a re-appraisal of the register obviously makes it simpler for the necessary services to be concentrated on those in need, and is coming to provide a more realistic picture of the volume of work which may become the main providence of work of the full-time Welfare Officer referred to earlier in this report.

Communications

Finally I would like to return to one of the opening points I made in this report, namely the establishment of lines of communication with other related services in the welfare field. It is easy to speak of the universally expected need of close team work in the Welfare Services, but I think that real progress has been made in this direction during the year. Secure links have already been forged within the Health and Welfare Department to which I have referred already, namely the meeting of nursing staff, staffs of Homes, Teachers of the Blind and Administrative Officers, both in arranged meetings and in cross visitation. With regard to connections with voluntary organisations, I have dealt with this in a little more detail under the heading of Voluntary Services following this report where the machinery for implementing Circular 3/62 is described. With regard to District Councils, I have already mentioned the close liaison required for the establishment of Grouped Dwelling schemes with welfare facilities, and a further significant point of contact during the year was the implementation of Circular 12/62 on Meals and Recreation for Old People. A consultation with District Councils on this subject established what I regard as a very satisfactory arrangement whereby the actual adminisration of Meals on Wheels and Luncheon Club arrangements in conjunction with Voluntary Bodies, is left with this department, while most of the District Councils are playing a part by making a contribution to the cost of such a service.

Both in regard to links with District Councils and in many other matters I am increasingly looking to the District Medical

Officer of Health who is also an Assistant County Medical Officer to be the effective leader of the local team. This point has already been brought out in this report on the matter of Group Dwellings Schemes, and will, I hope, come to its full value when the form of area administration is finally agreed by the County Council. The prospect here is of the Area Medical Officer having delegated administrative responsibilities for all health and welfare services as a co-ordinated whole. The professional and administrative heads of departmental sections, including the Welfare Services Officer, regularly attend the bi-monthly conference of the Assistant County Medical Officers, and this in itself has proved a most useful point of contact.

Finally I would like to express appreciation of the substantial amount of help and advice received from the officers of the Ministry of Health, as well as, to a more limited extent, of the Ministries of Labour and National Assistance. The Regional Welfare Officer, Ministry of Health, Newcastle, Miss Z. Williams, has followed with close interest the development of welfare services in the county, and has been most helpful at all times.

I believe that a very sound basis for the future development of the welfare services has been laid by the County Council in their approval of the 10 year programme. As the new buildings come into use year by year and staff is built up in parallel, I am confident that the elderly and the handicapped in Cumberland will be well cared for.

Voluntary Services

With the introduction of the welfare state in the immediate post-war years it was a common conception that, in future, the state would provide for all the needs of modern living, and that voluntary service would not be needed or that the voluntary spirit would be crushed by the state machine.

Voluntary effort not only continues, but in the last year or two there has been more official concern for the expansion of voluntary effort than for many years past. Following the publication by the Ministry of Health of a hospital plan for England and Wales and their call to local authorities to prepare a ten year development plan, specific and pointed reference was made to the scope for a much greater element of voluntary effort in the health and welfare services.

Here in Cumberland a highly satisfactory degree of co-operation already existed between the Health and Welfare Department and the voluntary organisations. However, bearing in mind the increase in the volume of need for services within the scope of welfare which will be seen in coming years, it became apparent that to ensure a proper plan for voluntary effort regular consultation was of paramount importance. It was also realised that three requirements all concerning information were essential if co-ordination was to be effective. The first of these was information from voluntary effort to the statutory authorities: the necessity of getting across what it was that voluntary effort had to offer and how much it could do if asked. The second was in a reverse direction: the statutory agencies must tell the voluntary organisations very clearly what they wanted from them. Finally, there is a need to inform the public at large how much more there is for them to do, and what scope exists for the undoubted reserve of voluntary effort and energy.

Reviewing the ways in which more voluntary help could be used to supplement statutory services provided by the County Health Department, it was felt that possible extensions and improvements could be made to some existing services such as elderly visiting, meals on wheels, assistance at clinics, hospital care service and distribution of welfare foods. Looking ahead, other services appear to have definite promise of useful work for many voluntary helpers. Those coming to mind, include day and night

sitter-in services, diversional occupations for the handicapped, escort and transport services for the elderly and handicapped, diversional occupations and trolley shops in local authority homes, help in local authority homes at times of staff shortage or illness, participation in handicapped classes, lunch clubs, and help in housing centres and hostels for the mentally disordered.

To harness the various organisations so that the maximum effort and minimum duplication results the County Council decided to establish seven area committees — covering the entire County and meeting the voluntary organisations working in their areas at regular intervals. The linch-pin of these committees will be the appropriate District Medical Officer of Health and other representatives of the statutory team would possibly include Nurses, District Welfare Officers, Mental Welfare Officers, District Housing Officers and Youth Officers. That is the possible composition of the committees, but as no tied pattern can be evolved to cover all circumstances in a given area, the aim will be to get adequate representation of likely participating voluntary bodies by leaving the constitution of the committees fluid.

I expect these committees to be set up in early 1963, and I look forward to a great increase in the number, and changes in the nature of items being carried out by voluntary bodies in the County. In formulating these plans I have been fortunate in having the help of the Council of Social Service and their help will also be invaluable in determining the pattern of training courses and tutorials for voluntary workers.

Without doubt, effective community care depends upon enlightened statutory action in combination with skilled voluntary services. This doctrine of partnership is fully accepted in Cumberland and in the coming years I look forward to observing its application in many different contexts.

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

INFECTIOUS DISEASES

The table of notification of infectious diseases, from which has been omitted those conditions showing a "nil" return, such as smallpox, diphtheria and typhoid, shows a high figure only against measles. That this too is destined to fade in the face of a vaccine in the years ahead, seems possible. Dysentery and Food Poisoning continue to contribute a sufficient number of cases to maintain awareness of their ubiquity and persistence as a problem, and the necessity for sustained Health Education of young and old on standards of personal and kitchen hygiene. As more fully stated elsewhere in this report, the reluctance of pulmonary tuberculosis to make its final bow underlines the requirement of continued vigilance in this field.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES, 1962

	Scarlet Fever.	Whooping Cough.	Ac. Poliomyelitis Paralytic.	Measles.	Dysentery.	Meningococcal Infection.	Tuberculosis: Acute Pneumonia.	Tuberculosis: Acute Encaphalitis Post Infectious.	Erysipelas.	Food Poisoning.	Tuberculosis: Respiratory.	Tuberculosis: Meninges and C.N.S	Tuberculosis: Other.	Tuberculosis: Puerperal Pyrexia.
URBAN DISTRICTS —														
Cockermouth ...	—	—	—	3	5	—	1	—	—	1	5	—	—	—
Keswick ...	—	—	—	—	—	—	—	—	—	—	1	—	—	—
Maryport ...	2	—	—	393	2	—	1	—	—	—	4	—	1	—
Penrith ...	2	—	—	189	2	—	1	—	1	—	6	—	—	2
Whitehaven ...	1	—	—	383	—	—	6	—	1	1	19	1	1	9
Workington ...	9	—	2	716	—	5	3	1	—	—	18	—	5	13
RURAL DISTRICTS—														
Alston ...	—	12	—	1	3	—	1	—	—	—	—	—	—	—
Border ...	6	7	—	37	58	—	2	—	—	—	8	—	—	—
Cockermouth ...	6	—	—	262	17	—	3	—	—	—	10	—	—	—
Ennerdale ...	2	1	—	229	—	1	2	—	—	6	13	—	4	8
Millom ...	—	1	—	95	11	—	—	—	1	—	5	—	—	—
Penrith ...	1	—	—	44	12	—	—	—	—	32	2	—	—	—
Wigton ...	6	18	—	133	39	—	20	—	1	—	3	—	1	—
TOTAL FOR YEAR ...	35	39	2	2485	149	6	40	1	4	40	94	1	12	33
1961 ...	57	72	4	2204	149	—	85	—	10	15	80	—	15	21
1960 ...	114	392	—	1999	35	2	83	1	6	95	126	1	16	9
1959 ...	254	153		3363	21									

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

Food and Drugs Act, 1955

Summary of work done under the above Act during the year ended 31st December, 1962

	Total Samples Obtained		Genuine		Unsatisfactory	
	Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
Submitted to Public Analyst ...	58	216	18	204	40	12
Tested by Sampling Officers ...	483	—	460	—	23	—
	541	216	478	204	63	12
	757		682		75	

Milk

58 samples of milk, including 12 " appeal to cow " samples (taken at time of milking) and 4 " reference " samples (taken at time milk passes from producer to retailer) were submitted to the Public Analyst during the year. Adverse reports were received on 40 of the samples.

483 samples of milk, tested by the sampling officers and not submitted to the Public Analyst, were satisfactory with the exception of 23 found to be slightly below standard. In such cases it is the practice to take further samples at a later date to see that the quality has improved, or in the case of informal samples, formal ones from the same source are taken as soon as possible for submission to the Public Analyst.

The presumptive standard for milk, other than Channel Islands quality, is 3.0 per cent. fat and 8.5 per cent. solids-not-fat. (Channel Islands — 4.0 per cent. fat.) The average quality of the samples tested by the sampling officers was 3.69 per cent. fat and

8.69 per cent. solids-not-fat, these are figures including the unsatisfactory samples, but not including any submitted to the Public Analyst.

Of the total number of milk samples taken, the percentage of unsatisfactory samples was 11.6.

The 40 milk samples certified by the Public Analyst to be unsatisfactory were dealt with as follows:—

Two prosecutions were undertaken in respect of milk containing added water. Two partners were each fined £30 in respect of seven samples and another farmer was fined £25 in respect of four samples.

Two producers were cautioned concerning seven samples deficient in non-fatty solids. Although it was apparent that these samples contained added water, the Analyst was unable to confirm this fact as he was unable to apply a freezing point test due to the milk being sour.

One farmer was cautioned for selling milk deficient in fat (seven samples involved) and advised to take steps to improve the quality. The fat deficiency was apparently due to an incorrect diet, for as soon as this was changed the quality of the milk began to improve.

The remaining fifteen unsatisfactory samples were instances of sub-standard, but genuine milk and the producers were notified of the results to enable them to take steps to try and improve the quality.

Foodstuffs Other than Milk

A total of 216 samples of various foodstuffs and drugs were taken during the year, 204 being genuine and 12 (5.5 per cent.) unsatisfactory.

Two samples of chocolate (cream filled bars) were found to be faulty due to an attack by grubs. The first sample was submitted as a result of a complaint and the second sample was a bar of similar chocolate purchased by the sampling officer at the same shop. It should have been apparent to the shopkeeper that the chocolate was faulty from the state of the wrappers. He was prosecuted and fined £5.

A sample of orange squash contained an excess of sulphur dioxide preservative and the attention of the manufacturer was drawn to this variation.

A jar of chicken fillets (foreign produce) was found to contain a metal clip, of the type used in the poultry trade, embedded in part of the chicken flesh. It was felt that to take action against the importers, who were legally responsible, would be unjust, especially in view of a very reasonable explanation offered by the Dutch manufacturers. This firm has taken steps to try and prevent such an occurrence in the future.

Two samples of rum butter were certified to be deficient in rum content. One was an informal sample and the deficiency may have been due to evaporation during the time the rum butter was kept in stock, as a formal sample taken on the manufacturer's premises was found to be satisfactory. The manufacturer was advised to allow for evaporation losses. The second unsatisfactory sample had a rum content much below the average, there being no legal standard, and the ingredients were not listed in the correct order. Enquiries showed that this rum butter was only made in small quantities and after the provisions of the Act and Regulations were explained to the person concerned, he willingly agreed to increase the rum content and to amend the labels on the containers.

Two samples of jam were deficient in soluble solids. Both types had been in stock for a long time and the shopkeepers agreed to withdraw the few remaining jars from sale.

A sample of ice cream showed a deficiency in fat and non-fatty solids. Other samples of ice cream from the same source had always been satisfactory and it appeared that a genuine mistake had been made in this particular mixing. The manufacturers were cautioned.

Some cream doughnuts were found to have a filler of imitation cream and not fresh cream. The bakers were cautioned for failing to make a declaration that imitation cream was being used in their products.

Minor offences concerning labelling infringements came to light with regard to samples of stewed steak and stomach powder. It was found that tins of steak of newer stock had labels which had been properly amended. The matter concerning the stomach powder was referred to the manufacturers to enable them to amend their declaration.

Complaints — Unsatisfactory Foodstuffs

Apart from the bars of chocolate already referred to, a few other complaints were received from members of the public and fully investigated.

One complaint resulted in a butcher being prosecuted for selling mouldy pork pies unfit for human consumption. However the magistrates dismissed the case on the grounds that there was insufficient evidence to prove that the pies were mouldy at the time of purchase, but they also stated that it was a proper case to bring before the court.

A multiple firm of grocers was prosecuted for selling bacon unfit for human consumption, it being infested with grubs. In this instance the complaint was made by a housewife soon after she had purchased the bacon and the firm was fined £25.

Milk (Special Designation) Regulations

These Regulations require that all milk sold by retail is in bottles or cartons and that correct designations must be applied to the milk. In an isolated area where a farmer has only a few customers and does not have a T.T. licence, and where no alternative supply of bottled milk is available, he is granted a Consent by the Ministry which exempts him from the Regulations. The number of householders being supplied with milk under Consents is very small and most of the milk sold throughout the county is either bottled or in cartons, correctly designated. There have been isolated cases of dairymen using cartons not properly labelled but these were found to be from old stock of the type in use before the Regulations came into force, and which had been put into use pending new supplies being received.

WATER AND SEWERAGE

Water Schemes

During the year the process of transfer of Water Undertakings from District Councils to the newly formed Water Boards continued. The Wigton Water Undertaking was transferred to the West Cumberland Water Board on the 1st April, 1962, and later in the year the Ministry made an order transferring Keswick also to the West Cumberland Water Board. The Eden Water Board was constituted, to take over (at 1st April, 1963) the Undertakings of the Penrith Rural, Penrith Urban and Alston Rural Councils.

The County Council contributes towards the expenses of all the Water Boards in the County and has a representative on each. During this change-over period very few new schemes were submitted. There were two small extension schemes from the West Cumberland Water Board, one from Alston, whilst the only large scheme was submitted by Carlisle Corporation covering proposals for major capital works in the Border area, to be carried out over the next seven years.

Sewerage Schemes

Seven new schemes were submitted during the year from the following District Councils:—

Border	(2)
Ennerdale	(3)
Wigton	(1)
Penrith	(1)

One of the Border schemes was an outline scheme to serve the villages of Corby Hill, Little Corby, Warwick Bridge and Warwick, and the second was a scheme to connect forty properties in the Durdar area to the Carlisle City sewerage. Both were approved as sound and adequate.

Of the Ennerdale schemes one was for new proposals to deal with the sewerage from Cleator Moor, Cleator and neighbouring communities. This scheme was to replace the proposed sea outfall at St. Bees and was approved as sound and adequate.

The other two schemes were:—

(a) The Cleator Bridge Outfall Sewer to link Cleator Moo with the proposed Cleator Bridge Treatment Works;

(b) Proposals for dealing with St. Bees sewerage.

Decisions on these two schemes were deferred pending the submission of further details.

The Wigton scheme was for Sewers and Treatment Works for the village of Oughterby and this again was deferred until a decision has been reached by the District Council as to whether farm waste is to be included. It is anticipated that the operation of the Rivers (Prevention of Pollution) Act and the Public Health Act, 1961, will jointly have a considerable affect on the sewerage of rural areas and farms.

The Penrith scheme was to provide sewers and disposal works in the villages of Stainton and Newbiggin and was approved as sound and adequate.

Notification of Ministry Grant in respect of Penrith Rural District Council's Armathwaite scheme and the Cockermouth Rural District Council's Thornthwaite scheme was received and the County Council made similar contributions.

Water Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Remarks
				Ministry	County	
Alston R.D.C.	Water Main Extension	1700 yards extension to serve 3 farms and 2 houses	£954	£271	£271	Complete
West Cumberland Water Board	Supply to Brackenrigg	Small mains extension to serve 3 houses	£900	£299	£299	Approved as sound and adequate
Carlisle Corporation	Carlisle Water Undertaking	Major capital works and minor improvement in the Border area	£172500	—	—	Corporation informed that the works proposed form a suitable basis on which a sound and adequate system may be designed

Sewerage Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Remarks
				Ministry	County	
Border R.D.C.	Warwick Bridge and District Sewerage and Sewerage Disposal Works	Outline scheme for the sewerage of the villages of Corby Hill, Little Corby, Warwick Bridge and Warwick, and construction and treatment works	£53050	—	—	Border Council informed that the schemes appear capable of development to provide a sound and adequate system of sewerage and sewerage disposal
Border R.D.C.	Durdar Sewerage	To connect sewerage from 40 properties to Carlisle City system	£7800	—	—	Approved as sound and adequate

Submitted by	Scheme	General Outline	Estimated or Final Cost	Grants		Remarks
				County	Ministry	
Ennerdale R.D.C.	Cleator Moor and District Sewerage Scheme	Scheme to provide for Cleator Moor and district by way of Treatment Works instead of the proposed Sea Outfall which was found to be unsatisfactory	£219000	—	—	Approved as sound and adequate
Ennerdale R.D.C.	Cleator Bridge Outfall Sewer	Scheme to link Cleator Moor with the proposed Cleator Bridge Treatment Works by means of 15 in., 18 in. and 21 in. pipes	N/A.	—	—	Consideration of scheme deferred pending further details from District Council
Ennerdale R.D.C.	St. Bees Sewerage Disposal	Scheme to deal with sewerage disposal for St. Bees	N/A.	—	—	Consideration of scheme deferred pending further details from District Council
Penrith R.D.C.	Stainton and Newbiggin Sewerage Scheme	To provide sewers and disposal works in the villages of Stainton and Newbiggin	£59900	—	—	Approved as sound and adequate
Wigton R.D.C.	Oughterby Sewerage and Sewerage Disposal Works	To provide sewers and Treatment Works for the village of Oughterby	£9000	—	—	Deferred until the District Council reach a decision on charges for farm wastes

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1962

(N.B.—Corresponding figures for 1961 are shown in brackets where possible)

	Alston R.D.C.	Border R.D.C.	Cockermouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Whitehaven Borough	Workington Borough	Cockermouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population — 1951	2327	29845	20455	29676	13428	11723	23746	24620	28891	5235	4868	12234	10492
(Census) — 1961	2198	29647	20886	30870	15037	11606	21868	27541	29507	5823	4752	12334	10931
1. Total number of occupied dwelling houses in the district	852 (855)	8681 (8425)	6555 (6473)	9525 (9406)	4462 (4573)	3770 (3663)	7206 (7166)	7681 (7745)	8942 (8870)	2280 (2069)	1629 (1670)	3990 (3999)	3479 (3439)
2. Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	3 (13)	— (6)	18 (6)	112 (146)	— (27)	23 (15)	11 (22)	94 (141)	37 (68)	51 (87)	7 (7)	77 (88)	24 (12)
3. Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost .	31 (44)	236 (241)	87 (28)	726 (557)	64 (66)	91 (114)	270 (222)	200 (200)	10 (60)	185 (190)	7 (7)	136 (140)	80 (92)
4. Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	70 (80)	640 (720)	Not Known (Not Known)	1279 (1650)	297 (318)	470 (480)	1259 (1283)	Not Known Not) Known)	70 (50)	28 (28)	95 (95)	89 (103)	60 (56)
5. Number of houses found to be overcrowded	6 (7)	17 (14)	9 (2)	6 (6)	8 (7)	40 (45)	5 (6)	— (4)	— (—)	— (—)	— (—)	— (—)	2 (2)
WAITING LISTS													
Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above	21 (22)	236 (245)	448 (490)	579 (505)	246 (211)	Nil (Nil)	426 (402)	952 (880)	886 (900)	322 (56)	140 (No list kept)	351 (316)	202 (254)
NEW HOUSES COMPLETED DURING THE YEAR													
By or for the Council													
For aged persons	4 (—)	4 (8)	3 (9)	10 (30)	8 (24)	6 (4)	10 (6)	— (12)	— (8)	— (6)	— (—)	— (—)	— (—)
For aged persons grouped with welfare facilities	—	—	—	—	—	—	20	—	—	—	—	—	—
For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (6)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
General purpose dwellings	10	—	8	152	6	8	18	107	45	36	14	5	2
2. Private building	1 (—)	192 (136)	86 (113)	111 (180)	52 (54)	29 (28)	24 (45)	24 (80)	69 (72)	9 (35)	— (2)	2 (1)	16 (32)
Total of 1 and 2 ...	15 (—)	196 (195)	97 (181)	273 (272)	66 (78)	43 (36)	72 (103)	131 (145)	114 (130)	45 (41)	14 (22)	7 (26)	18 (54)
1. Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants) ...	14 (7)	63 (106)	40 (76)	60 (73)	67 (86)	56 (57)	63 (106)	25 (17)	41 (79)	9 (8)	13 (6)	25 (32)	20 (21)
2. Number of houses for which grants were approved	14 (7)	59 (105)	40 (74)	60 (67)	67 (84)	55 (54)	62 (104)	19 (16)	40 (77)	9 (8)	13 (6)	25 (32)	18 (19)
3. Number of houses where improvements were carried out and grants paid	7 (8)	66 (79)	55 (51)	55 (43)	54 (69)	50 (40)	101 (47)	13 (15)	51 (63)	7 (2)	11 (9)	22 (28)	11 (16)
4. Number of houses purchased or taken over by the Council with a view to improvement or conversion	— (—)	— (1)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	1 (—)
5. Number of houses improved by the Council, with grant	— (—)	1 (—)	— (—)	3 (3)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	1 (5)	— (—)	— (—)
HOUSING PROGRAMME													
Estimated number of dwellings to be built during the ensuing year													
By or for the Council													
For aged persons	—	5	9	53	18	26	26	—	—	—	20	40	4
For aged persons grouped with welfare facilities	12	25	15	24	—	—	—	—	—	20	—	—	27
For agricultural workers	—	—	—	—	—	—	—	—	—	—	—	—	—
General purpose dwellings	—	24	62	199	28	—	54	125	120	91	40	60	7
2. Private building	1 (—)	Not Known (Not Known)	90 (100)	100 (160)	40 (75)	30 (20)	14 (30)	30 (80)	60 (60)	45 (32)	2 (6)	50 (25)	50 (57)
Total of 1 and 2 ...	13	54	176	376	86	56	94	155	180	156	62	150	88

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

III. Mass Radiography.

IV. County Council Clinics.

APPENDIX I

Annual Report on Tuberculous and other Chest Diseases in East Cumberland in 1962

Introduction

The trends noted in last year's report have continued.

The number of new cases of pulmonary tuberculosis discovered throughout the whole of the East Cumberland Hospital Management Committee area was 52. Unfortunately, of the 52 cases of tuberculosis for the year, a large proportion of these had extensive disease with a positive sputum when first seen; many of these had never had a previous X-ray examination — most disappointing considering we have been operating a mass radiography service in the area since 1951.

On the 1st January, 1962, the total number of cases of tuberculosis on the active register had dropped to 1,288, and on the 31st December, 1962, this figure had further fallen to 928.

The number of new cases of pulmonary neoplasm remains at a steady high level; there were 60 new cases last year compared to 64 for 1961. Here again the vast majority of these cases have never had a previous X-ray examination, and as a result all except two were found to be unfit for surgery.

Unless individuals, and particularly those over the age of 40, get into the habit of having an annual X-ray examination, this unsatisfactory state of affairs is bound to continue. Of the 60 new cases of cancer discovered more than half came from the City of Carlisle and the immediately surrounding area, so that frankly there is no excuse for patients presenting themselves with extensive disease and saying that they have never had an X-ray examination before. The Hospital Board have provided the facilities, but these are still not being adequately used.

We now have two mass radiography units in the area, one of which is permanently based at the Mass Radiography base at Warwick Road, Carlisle. Not only are numerous surveys carried out in factories and other establishments, but we do endeavour now to carry out street by street surveys for a period each year in black spots in the whole area.

Tuberculosis

Table 1 shows the number of notifications in the East Cumberland county area for the past eleven years:—

Table 1

Year	Pulmonary	Non-Pulmonary
1952	79	20
1953	63	18
1954	66	19
1955	56	20
1956	54	10
1957	54	12
1958	47	15
1959	50	11
1960	19	6
1961	28	8
1962	23	2

Table 2 gives the number of pulmonary and non-pulmonary cases on the Clinic register at the end of 1962, for the same area.

Table 2

Pulmonary	Non-Pulmonary
369	53

There has been little change in the programme of therapy in tuberculosis. Streptomycin retains its value as the most effective drug, but Isoniazid comes a close second and is relatively cheap. Some of the other drugs are much more expensive, but fortunately these expensive second-line drugs are only needed in a few cases as most patients can be made non-infectious with a combination of Streptomycin, Isoniazid and Paramisan. Fortunately too, in this area, there is no evidence of any increase in the incidence of organisms resistant to the three main drugs. In all new cases, organisms are, if possible, isolated and their sensitivity tested.

The four chronic cases which were noted in the 1961 report as being resistant to the drugs are still alive, but no cases of primary resistance to even one of the three main drugs was noted during 1962. This is most satisfactory. In Britain in 1961 there was, throughout the country, an overall 5 per cent. to 6 per cent. of primary resistance to one at least of the three main drugs. In 1955 the percentage of primary resistance throughout the country to the three main drugs was respectively — Streptomycin 2.3 per cent., Paramisan 2.2 per cent., and Isoniazid 0.7 per cent. As

long, however, as we have even four patients who are resistant to these drugs there is a recognition for new drugs in the treatment of the disease.

It is essential to know the drug susceptibility of the patient's organisms when mapping out the programme of therapy in newly diagnosed patients; although one has to wait for cultures before the results are available, treatment can be initiated with these drugs in combination, and in combining these there is little risk of acquiring resistance. The problem of resistance is a strong argument against inadequate therapy, and in such countries where many cases of active disease are treated with Isoniazid alone there is a great risk of further epidemiological and clinical problems.

Although surgery is being used less and less for tuberculosis, there still remains the odd case who will require surgery. There is no doubt that combined drug therapy is most effective in the vast majority of cases, but a good end result is often quicker attained by combining the drug therapy with resection in cases where persistent cavitation remains.

No new case of tubercle was discovered in immigrants during 1962, so that one hopes that our experience in 1961, when we discovered six such cases, was an isolated one.

Contact work has continued and Table 3 shows the number of new contacts in the East Cumberland County Area examined during the year, and of these the number vaccinated with B.C.G. vaccine.

Table 3

Year	No. of NEW contacts seen	No. diagnosed as tuberculous	No. vaccinated with B.C.G. vaccine	No. of hospital staff, additional to Col. 1 and vaccinated with B.C.G. vaccine
1956 ...	920	4	84	27
1957 ...	1126	5	143	34
1958 ...	986	3	155	48
1959 ...	1152	6	156	50
1960 ...	906	—	100	39
1961 ...	898	4	135	43
1962 ...	959	1	124	32

Routine examinations of old contacts continue to be largely carried out through the mass radiography units as this relieves the chest centre of considerable extra work.

There is no doubt as to the value of B.C.G. vaccination. I feel it is essential to be sure that protection has been given by carrying out a post-vaccination Mantoux test. The presence of a negative Mantoux test requires re-vaccination. Statistics show that cases of pulmonary tuberculosis developing in vaccinated subjects are invariably in those where the Mantoux test has not been converted.

Cancer of the Lung

Table 4 shows the number of new cases of cancer of the lung seen at the chest centre during the previous eight years:—

Table 4

Year		East Cumberland
1955	...	12
1956	...	11
1957	...	11
1958	...	17
1959	...	31
1960	...	20
1961	...	30
1962	...	29

In 1960, 24,800 people in the United Kingdom died from lung cancer, 29,000 from bronchitis, and 104,5000 from coronary arterial diseases, and of those who died many were men not more than middle-aged.

Cancer chemotherapy remains inadequate. The object of any therapy is to destroy the cancer cells without causing irreparable damage to normal tissues. The difficulty is that the differences, so far discovered, beween tumour cells and normal cells, are small and are usually of degree only. In addition, there are many types of tumour and it is unlikely that all tumours will have a common biochemical abnormality which can be exploited by a single chemical agent.

Because of the small biochemical differences between tumour and normal cells, drugs must be administered closest to the largest dose which can be tolerated. The use of drugs has been well proved in cases of cancer of the breast and of the prostate, they are valuable in some of the leukaemias, but, so far, in lung cancer they have been disappointing. Drugs can be used in combination with surgery, or with radiotherapy.

As far as surgery is concerned, lobectomy is preferred to pneumonectomy, and there is no doubt that some cases do well and survive five to ten year periods. Although the number of cases sent for surgery is relatively small, one has the impression that upper lobe tumours do better than those situated elsewhere. Unfortunately, many cases when first seen also have pleural effusions and these are an absolute contra-indication to surgery.

The reports on Mega-voltage X-ray therapy in cases of cancer are disappointing, and there is probably little advantage in using this over the usual 240 Kilo-voltage therapy. The chief value of both is in the relief of pain and the cessation of bleeding.

Bronchitis

The crude death rate in England and Wales is roughly 58 per 100,000, and this rate has tended to rise over the past 12 years particularly in men over the age of 45. When the actual morbidity resulting from the disease is considered in addition to the mortality, bronchitis undoubtedly constitutes one of the most serious pulmonary diseases. Many factors, some known and some unknown, have very considerable bearing on this disease, for example cigarette smoking and air pollution. Every effort therefore should be made to reduce both these factors. Treatment of the disease in its early stages by adequate antibiotic cover can not only cut short the attacks, but by adequate control and physiotherapy, can diminish their frequency, and even be lifesaving.

Many of the younger persons who suffer from bronchitis and also from asthma have very considerable postural defects; others, after their initial attack, are quite unable to breath properly. Unless corrected, these defects are likely to worsen and thus contribute greatly to further attacks of bronchitis or asthma; otherwise the maximum breathing capacity remains low, the lungs remain small, and alveolar hypo-ventilation results, the whole progressing finally to pulmonary hypertension and cor pulmonale.

Sarcoidosis and Bronchiectasis. There are still comparatively large numbers of patients under treatment for both sarcoidosis and bronchiectasis. The number of new cases of the former disease remains at a fairly steady level, but there has been an undoubted drop in the new cases presenting with bronchiectasis.

In-Patients. Table 5 shows the number of in-patients treated during 1962.

Table 5

Unit	No. of beds available	No. of patients admitted in 1961	No. of patients admitted in 1962	No. of patients with tuberculosis admitted in 1962
*Ward 18 ... Cumberland Infirmary	13	212	201	15
Longtown ... Chest Unit	26	123	120	39
Blencathra ... Hospital	25	58	65	45

* Ward 18, closed for two months early in 1962

APPENDIX II

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1962

During 1962, the favourable aspects of tuberculosis control to which attention was drawn last year, were maintained. With figures for both morbidity and mortality rates standing at a low level, some annual variation — due more to chance than to any epidemiological phenomenon — can be noted. Neither the number of notified cases in the year nor the death rate has shown any marked change: but at the time of writing it is apparent from the remarkable paucity of both cases and deaths in 1963 so far, that an averaged figure for a two year period would reflect more accurately current trends.

The usual data showing the prevalence and impact of tuberculosis upon the community's health follow.

New Cases

The total number of new cases of all forms of tuberculosis was 92. Notifications were highest in Workington (27), Whitehaven (25) and Ennerdale (19); followed by Cockermouth (11), Maryport (9) and Millom (3).

Of the 92, some 25 were frankly sputum positive at diagnosis, the men (16) twice as frequently so as the women (8).

The Case Rate based on the Registrar General's mid-year estimated population for West Cumberland of 142,522 persons was 0.64/1,000.

Tuberculosis Register

The Clinic tuberculosis register at the 31st December, 1962 contained the names of 868 cases of all forms of tuberculosis. This compares with 990 for 1961; 1138 for 1960 and 1529 for 1959: i.e. there are now approximately half the number of cases of 3 years ago.

Of the 19 deaths during the year of cases on the Register, 8 were attributable to tuberculosis, the remainder dying of other causes. The mortality rate for 1962 was thus 0.05/1,000, the same figure as in 1961.

Recovered cases totalled 140. Cases on the Register before 1962 (776) and where disease during the year was quiescent or attained quiescence totalled 740, showing again an improvement on the figures for 1961 — 95 per cent. quiescent compared with 93 per cent. then.

The proportion of cases frankly infectious at diagnosis showed a welcome decline — 25 in 92 new cases, as against 24 in 64 for 1961.

Summary of Chest Clinic Statistics

Outpatient sessions have continued in the Chest Clinics at Workington, Egremont and Millom. When convenient, some few outpatients have attended also at Homewood. Workington Chest Clinic remains the centre for records and clinic administration. At Workington, 265 sessions were held, at which 1041 new patients were seen, attendances totalling 3,050 persons. By far the largest category of patients now attending the clinics is the group of non-tuberculosis chest disorders, of which chronic respiratory insufficiency, bronchitis, asthma, pneumoconiosis, lung cancer and upper respiratory tract ailments constitute the majority.

At Egremont, 170 sessions were held for 815 new patients and a total attendance of 2,946: Millom figures were: 11 sessions, 53 new patients and 171 total attendances.

For the group, 446 sessions were held for 1,909 new patients with total attendances of 6,167. (5,895 in 1961).

Contacts of Tuberculous Cases

Familial contacts of cases on the Register seen during the year totalled 1,237: of these, new contacts amounted to 780. This group is made up largely of children: adults, in the main, are referred to the Mass X-Ray Unit. Of the children seen at the Clinics, 514 were skin tested with 1/1000 old tuberculin: reactors numbered 39. Regrettably 10 children from amongst this group were found suffering from notifiable disease — 8 respiratory and 2 non-respiratory forms. The reactor — rates for three main age groups 0 — 4 years, 5 — 9 years and 10 — 14 years of age were disturbingly high, particularly the youngest group where a rate of 3.1 per cent. infected indicates again exposure to infection at a dangerously tender age: and undoubtedly occurring in the household. In the 5 — 9 years group, 11.3 per cent. were found infected and in the next age group 19.4 per cent. Corresponding figures for 1961 were :—

0 — 4 years	nil infected
5 — 9 years	3.0 per cent.
10 —14 years	6.3 per cent.

The reactor rates for 1962 in this group of young people are the worst for more than 4 years and again underlines the danger of continuing complacency.

Case Finding Procedures

By suitable re-arrangement of the daily work programme of radiographer and nursing staff duties at the Chest Clinics, open sessions for general practitioner referral for x-ray and immediate report on the wet films were made available at Workington. Two sessions weekly additional to the regular consultative time-table have now become firmly established. At Whitehaven, where large film x-ray facilities are not available for the Chest service, the Mass X-Ray Unit has held a regular session on Friday of every week. Attendances at the Whitehaven unit have not been included in Chest Clinic figures; nor is there any reflection in the figures of the routine ante-natal chest x-ray programmes carried out at Workington Infirmary, Whitehaven Hospital and Maryport Cottage Hospital. These regular screening procedures of the apparently normal population augment the Mass X-Ray activities, a summary of whose work follows on page 171.

Attention is drawn to the extremely interesting analysis contained in Table 4 of the Annual report of the Director of the Mass X-Ray Unit for the Special Area, which is printed on page 177, and which shows the trends of disease indentified by the Unit annually since 1955. There are now twice as many cases of fresh active tuberculosis found in East Cumberland as in West Cumberland. Attention is also drawn to the number of contacts known to have attended the M.M.R. Unit in West Cumberland — 456. The number of known contacts asked to attend in this area in the year was 4,631. In the several local health authority areas, the total of 4,631 is broken up as follows :

Workington	1,177	Cockermouth	349
Ennerdale	1,073	Millom	484
Whitehaven	847	Maryport	701

Ante-natal chest x-rays in the area totalled 1,263 (1,051 in 1961).

Workington	885	Whitehaven	378

Treatment

At Homewood, (Ward E, West Cumberland Hospital, Hensingham), 41 beds were available during the year: with an average daily bed occupancy of 30.11 (73.4 per cent.), waiting time for admission has been non-existent, apart from periodic shortages of female beds, unavoidable with the ward bed-distribution.

Source of Examination	Mini. films	Clinical exams.	Active T.B	Inactive T.B.	Br'sis	Neo-plasms	Pn'sis	Cardiac conditions
MOBILE UNIT—								
Doctors' cases	60	1	—	13	—	—	11	—
Contact cases	428	16	—	6	1	—	3	1
Students	768	4	—	—	—	—	—	1
General Public	6816	202	8	23	10	7	30	13
Surveys	6305	106	3	13	5	—	8	2
M.D. patients	285	13	—	—	2	—	—	—
Totals	14662	342	11	55	18	7	52	17

Source of Examination	Mini. films	Clinical exams.	Active T.B	Inactive T.B.	Br'sis	Neo-plasms	Pn'sis	Cardiac conditions
STATIC UNIT—								
Doctors' cases	325	45	1	6	1	2	6	1
Contact cases	1	—	—	—	—	—	—	—
Students	8	—	—	—	—	—	—	—
General Public	443	8	—	2	—	—	2	—
Employees	6	—	—	—	—	—	—	—
Totals	783	53	1	8	1	2	8	1

Discharges and deaths totalled 159 (154 in 1961 and 123 in 1960). Tuberculosis admissions totalled 95: non-tuberculosis conditions 64.

Patients sent to Seaham Hall for chest surgery totalled 12. (16 in 1961; 19 in 1960; 31 in 1959).

Carcinoma of Lung

The total number of cases seen at the Chest Clinics in the year was 21 (18 in 1961). The total number of deaths attributable to this cause in patients seen at the Clinics in 1962 was 13 (13 in 1961).

In keeping with general trends in medicine throughout the United Kingdom, the average age of patients now requiring special chest facilities is continually rising. In both tuberculous and non-tuberculous conditions, the major impact of disease is evident in the 65 years and older group. Procedures of hospital treatment and after care in chest illnesses are steadily evolving towards a much closer integration with the specialised skills of the Geriatric Unit and future development along these lines in West Cumberland is bound to occur.

APPENDIX III

MASS RADIOGRAPHY

REPORT ON THE WORK OF THE MASS RADIOGRAPHY UNIT DURING THE YEAR 1962

(NOTE—Figures given in brackets throughout the report relate to the corresponding figures for 1961.)

Both the Static and Mobile Units were fully operational throughout the twelve months with the exception of a period of two weeks when both Units were fitted with 100 mm camera units. The Leyland van was also modified, the original darkroom being converted into office accommodation and a small dry darkroom being provided in the front end of the vehicle. All processing of films is now done centrally at the base at 1 Brunswick Street, Carlisle. Here, the Static Unit is now open for six sessions weekly, one session being in the evening. Since May, 1962, the Mobile Unit has been used as a static unit at Whitehaven every Friday from 11.30 a.m. to 2.30 p.m.

Groups Examined

In addition to carrying out surveys at works and factories, surveys of the general public were carried out on 40 occasions. 927 (1,113) contact cases were X-rayed, 498 from the East Cumberland area and 429 from West Cumberland.

Results

41, 534 (35,807) persons were examined by the Units during the year. Of these 1,058 were referred for clinical examination.

Table 1 shows the number of abnormalities revealed during 1962 throughout the whole of the Special Area.

Table 1

Abnormalities revealed—	No. of cases found		Percentage of total examined	
(1) Non-tuberculous conditions:				
(a) Bronchiectasis ...	41	(33)	.10	(.09)
(b) Pneumoconiosis ...	60	(46)	.14	(.13)
(c) Neoplasm ...	34	(29)	.08	(.08)
(d) Cardiovascular conditions	89	(168)	.21	(.47)
(e) Miscellaneous requiring investigation ...	15	(36)	04	(.10)
(2) Pulmonary Tuberculosis:				
(a) Active ...	36	(31)	.09	(.09)
(b) Inactive requiring supervision .	77	(31)	19	(.09)
(c) Active (previously known) . .	—	(2)	. -	(.006)

Tables 2 and 3 give a detailed analysis of the work of the Units both Mobile and Static divided as between East and West Cumberland.

Table 2

MOBILE UNIT	EAST CUMBERLAND							WEST CUMBERLAND						
Source of examination	Doctors' cases	Contact cases	Students	School staff	General Public	Surveys	TOTALS	Doctors' cases	Contact cases	Students	General Public	Surveys	Mentally defective patients	TOTALS
Miniature Films	22	491	1695	200	12505	7782	22695	60	428	768	6816	6305	285	14662
Large Films	2	20	—	—	194	18	234	—	—	—	—	—	—	—
Clinical Examinations	—	13	11	1	248	131	404	1	16	4	202	106	13	342
Active Tuberculosis	—	—	1	—	8	4	13	—	—	—	8	3	—	11
Inactive Tuberculosis requiring supervision ...	—	—	—	—	4	2	6	13	6	—	23	13	—	55
Bronchiectasis	—	—	—	—	5	2	7	—	1	—	10	5	2	18
Neoplasms	—	—	—	—	4	1	5	—	—	—	7	—	—	7
Pneumoconiosis	—	—	—	—	1	1	2	11	3	—	30	8	—	52
Cardiac Conditions	—	1	—	—	42	11	54	—	1	1	13	2	—	17

Table 3

STATIC UNITS	CARLISLE					WHITEHAVEN					
Source of examination	Doctors' cases	Contact cases	General Public	Employees	TOTALS	Doctors' cases	Contact cases	Students	General Public	Employees	TOTALS
Miniature Films	1837	7	1066	484	3394	325	1	8	443	6	783
Large Films	43	—	5	1	49	—	—	—	—	—	—
Clinical Examinations	202	1	48	8	259	45	—	—	8	—	53
Active Tuberculosis	10	—	1	—	11	1	—	—	—	—	1
Inactive Tuberculosis requiring supervision	6	—	1	1	8	6	—	—	2	—	8
Bronchiectasis	12	—	3	—	15	1	—	—	—	—	1
Neoplasms	18	—	2	—	20	2	—	—	—	—	2
Pneumoconiosis	—	—	—	—	—	6	—	—	2	—	8
Cardiac Conditions	12	—	5	—	17	1	—	—	—	—	1

Table 4 gives the relative figures as between East and West Cumberland for the past eight years.

Table 4

Year	EAST CUMBERLAND						WEST CUMBERLAND					
	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1955 ...	51	455	10	363	38	3	60	302	1	70	25	80
1956 ...	46	338	8	360	37	3	56	258	2	53	15	61
1957 ...	37	312	7	368	18	2	24	226	4	72	24	92
1958 ...	40	153	10	321	27	2	16	81	4	90	16	125
1959 ...	33	40*	13	241	37	3	14	24*	4	39	15	71
1960 ...	21	11*	19	120	19	2	18	21*	7	23	9	52
1961 ...	20	11*	24	144	23	4	13	20*	5	24	10	42
1962 ...	24	14*	25	71	22	2	12	63*	9	18	19	60

* Requiring Supervision

Tables 5 and 6 refer solely to the area covered by the East Cumberland Hospital Management Committee. Table 5 shows the number of new cases of pulmonary tuberculosis discovered and Table 6 the number of new cases of neoplasm discovered in each case since 1955.

Table 5

Year	No. of new cases	Number with positive sputum	Percentage of new cases with positive sputum	No. of new cases referred by M.M.R.	Percentage of new cases referred by M.M.R.	Percentage positive sputum cases found by M.M.R.
1955 ...	139	42	30	43	31	21
1956 ...	125	39	31	39	31	18
1957 ...	125	42	34	33	26	29
1958 ...	117	32	27	29	25	9
1959 ...	116	31	27	28	24	6
1960 ...	72	28	39	21	29	18
1961 ...	58	20	34	20	34	20
1962 ...	52	22	42	23	44	24

Table 6

	1955	1956	1957	1958	1959	1960	1961	1962
No. of cases of neoplasm seen at Chest Centre ...	21	29	38	59	59	54	64	60
No. discovered by M.M.R. ...	10	8	7	10	13	19	24	25

Comments

The brief statistics given show that Mass Radiography continues to play a vital role in the discovery of both pulmonary tuberculosis and cancer of the lung. Of the 41,534 persons examined by the Units throughout the year in the Special Area no less than 9,368 had never had a chest X-ray taken previously, and the pick-up rate in these new examinees was very much higher in both diseases than in those who had previously been examined.

	Active Tuberculosis	Neoplasm
Previously X-rayed	22	23
Not X-rayed before	14	11

The percentage pick-up rates in both active tuberculosis and neoplasms of the Units in both East and West Cumberland is shown below.

	Static Unit Carlisle	Static Unit Whitehaven	Mobile Unit E. Cumberland	Mobile Unit W. Cumberland
Active Tuberculosis ...	.32	.13	.06	.08
Neoplasm ...	.59	.26	.02	.05

These figures again show the **high** pick-up rates at the Carlisle Static Unit. The general practitioners in the Carlisle area are making full use of this service. The Mobile Unit being operated

as a Static Unit in Whitehaven is still in the somewhat experimental stage but I feel that we should persevere wih the service there too.

There is no question but that all adults should have an annual chest X-ray examination so that early diagnosis of tuberculosis and lung cancer can be made and such conditions treated. I make no apology for repeating this once again. The Mass Radiography service should be directed generally to those persons or groups of persons who are specially at risk. As far as tuberculosis is concerned the contacts of new cases are expeditiously and comparatively cheaply screened by the Mass Radiography Unit. As far as lung cancer is concerned it would seem advisable for all pneumoconiotics to have an annual examination. Our efforts should continue to be directed towards people who have so far not had an examination and in this connection the street by street surveys which are undertaken in two areas for a period each year are not only conducive to this end but also greatly help in persuading the older age groups to pass through the Unit.

Acknowledgments

It is a pleasure to acknowledge once more the valuable help received in arranging these surveys from the Medical Officers of Health concerned in the area and from the Managements and Workers' Organisations in the factories visited.

It gives me great pleasure to acknowledge the great help and co-operation we have received from the general practitioners in the East Cumberland area. They have taken full advantage of the sessions of the Static Unit with considerable benefit to the patients concerned.

The interpretation of films and disposal of abnormalities is no easy task and would be impossible without the friendly co-operation of my colleagues on the hospital staff and to all I tender my sincere thanks.

I would also like to thank the numerous organisations who have in any way helped us, including the Police who continue to advise with regard to the traffic problems inherent in our surveys.

APPENDIX IV

County Council Clinics

Centre	Address	Clinic Services
Alston	Cottage Hospital, Alston	Child Welfare
Anthorn	2 Fell View, Anthorn	Ante-natal, Child Welfare, Dental
Aspatria	North Road, Aspatria	Ante-natal, Child Welfare, Dental, Speech Therapy, Welfare Foods, Orthopaedic
Brampton	Union Lane, Brampton	Child Welfare, Chiropody, Dental
Carlisle	14 Portland Sq., Carlisle	Child Guidance, Dental, Immunisation and Vaccination, Orthoptic, Speech Therapy, E.N.T., Ophthalmic, Orthopaedic
Cleator Moor	Jacktrees Road, Cleator Moor	Ante-natal, Child Welfare, Dental, Orthopaedic
Cockermouth	Harford House, Cockermouth	Ante-natal, Child Welfare, Chiropody, Dental, Immunisation and Vaccination, Orthopaedic, Speech Therapy
Egremont	St. Bridget's Lane, Egremont	Ante-natal, Child Welfare, Chiropody, Dental, Hearing Therapy, Chest, Orthopaedic, Speech Therapy
Frizington	Council Chambers, Frizington	Ante-natal, Child Welfare, Dental
Houghton	Village Hall, Houghton	Child Welfare
Keswick	13-15 Bank St., Keswick	Child Welfare, Dental, Immunisation and Vaccination, Speech Therapy, Ophthalmic, Orthopaedic
Longtown	Esk Street, Longtown	Child Welfare

Centre	Address	Clinic Services
Maryport ...	24 Selby Terr., Maryport ...	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Speech Therapy, Orthopaedic
Millom ...	18 St. George's Road, Millom ...	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments (G. P's.), Ophthalmic, Orthopaedic
Nenthead ...	Overwater, Nenthead ...	Child Welfare
Penrith ...	Brunswick Sq., Penrith ...	Ante-natal, Child Welfare, Dental, Orthoptic, Speech Therapy, Family Planning, Orthopaedic, Psychiatric
Scotby ...	Village Hall, Scotby ...	Child Welfare
Seascale ...	St. Cuthbert's Church Hall, Seascale ...	Ante-natal, Child Welfare, Immunisation and Vaccination
Seaton ...	Miners' Welfare Hall, Seaton ...	Child Welfare
Thornhill ...	Community Centre, Thornhill ..	Child Welfare
Wetheral ...	Village Hall, Wetheral ..	Child Welfare
Whitehaven—		
Flatt Walks ...	Flatt Walks, Whitehaven ..	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Chest, E.N.T., Ophthalmic, Orthopaedic
Mirehouse ...	Dent Road, Mirehouse, Whitehaven ...	Ante-natal, Child Welfare, Dental
Woodhouse ...	Woodhouse, Whitehaven ...	Ante-natal, Child Welfare, Immunisation and Vaccination

Centre	Address	Clinic Services
Wigton ...	Birdcage Walk, Wigton ...	Child Welfare, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Speech Therapy, Orthopaedic
Workington—		
Park Lane ...	Park Lane, Workington ...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Family Planning, Orthopaedic. **Note** — Spastic Therapy Clinics held about three times a year
Harrington ...	Methodist Hall, Harrington, Workington ...	Ante-natal, Child Welfare
Westfield ...	St. Mary's Parish Hall, Moss Bay, Workington ...	Child Welfare